GEORGIA DEPARTMENT OF PUBLIC HEALTH

NAME OF INDIVIDUAL/PATIENT	
DATE OF BIRTH	
ADDRESS	**CITY/STATE/ ZIP**

AUTHORIZATION FOR RELEASE OF NEWBORN SCREENING REPORT

1. I hereby voluntarily authorize **DPH** to disclose the medical information indicated below to_____.

2. The purpose for this disclosure is for _____.

3. The information to be disclosed includes:
___ Newborn Screening Report
___ Follow-up Notes
___ Other (specify)_____

4. Additional Information:

Mother's Name: _____
Mother's Date of Birth: _____
Hospital of Birth: _____
Patient's Gender: _____

5. This authorization shall become effective immediately and shall remain in effect until (date) or for one year from the date of signature if no date is entered.

I understand that I may revoke this authorization in writing at any time prior to the release of information from DPH, and that revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

I understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act.

_____ _____
Print Patient's Name Patient's Signature

_____ _____
Authorized Guardian or Representative Authorized Guardian or Representative Signature