GEORGIA DEPARTMENT OF PUBLIC HEALTH

# AUTHORIZATION FOR RELEASE OF LOW THC OIL CARD

| NAME OF PATIENT | |
|---|---|
| | |
| **DATE OF BIRTH** | |
| | |
| **ADDRESS** | **CITY / STATE / ZIP CODE** |
| | |

1. I hereby authorize _____ (health department) to disclose the medical information indicated below to _____ (authorized representative).
2. The purpose of this authorization is for the release of the patient's Low THC Oil card to the individual listed above.
3. This authorization shall become effective immediately and shall remain in effect until _____ (date) or for two years from the date of signature if no date is entered.

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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

_____ _____

Print Authorized Representative's Name | Authorized Representative's Signature

_____

Date

*****Kindly submit the completed form to your respective county health department upon retrieval of card accompanied by the representative's government-issued driver's license/identification and a copy of the patient's government-issued driver's license/identification. This will facilitate the verification process upon retrieval of the patient's Low THC Oil card.*