GEORGIA DEPARTMENT OF PUBLIC HEALTH

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION REGARDING COVID-19

Request for Proof of Recovery from COVID-19 To Enter the United States

Name of Patient/Individual	
Date of Birth	
Street Address	
City/State/Zip	
Date of COVID-19 Positive Test	
Testing Location	
Email address you want letter sent to	
Phone number	
Country from which you will travel to the U.S.	
Date of Arrival into the United States	

1. The undersigned, _____ (insert full name) hereby voluntarily authorizes the Georgia Department of Public Health (DPH) to disclose the medical information indicated below to me.

2. The undersigned, _____ (insert full name) hereby expressly consents to the DPH, through its Records Custodian, sending to me, by email a letter to serve as proof of recovery from COVID-19 in the past 90 days so that I may enter the United States.

This authorization shall become effective immediately and shall remain in effect until one year from the date of signature.

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.

Print Requestor's Name _____ Requestor's signature _____

Print Authorized Representative's Name (if applicable) _____

Authorized Representative's signature (if applicable) _____