GEORGIA DEPARTMENT OF PUBLIC HEALTH

NAME OF INDIVIDUAL/CONSUMER/PATIENT/APPLICANT	
DATE OF BIRTH	
Requesting Agency ID #	**Releasing Agency ID #**
40500	NA

AUTHORIZATION TO RELEASE INFORMATION

I hereby request and authorize: **The Georgia Cancer State Aid Program and its representatives**
(Name of Person or Agency Requesting Information)

Two Peachtree St. N.W., 16th floor, Atlanta, GA 30303
(Address)

to obtain from: _____
(Name of Person or Agency Holding the Information)

_____
(Address)

the following type(s) of information from my records (and any specific portion thereof):

Any information related to the enrollment application for the Cancer State Aid Program and reimbursement of medical services. This includes but is not limited to personal financial information, enrollments in other medical reimbursement programs, and medical information related to cancer treatment and current disease status.

for the purpose of: Cancer State Aid Program enrollment and reimbursement of medical expenses covered by the program.

I understand that the federal Privacy Rule (HIPAA) does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for: ***(PLEASE CHECK ONE)***

- ☐ *ninety (90) days unless I specify an earlier expiration date here:* _____
- ☐ *one (1) year*
- ☒ *the period necessary to complete all transactions on matters related to services provide to me.*

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

_____ (Date) _____ (Signature of Individual/Consumer/Patient/Applicant)

_____ (Date) _____ (Signature of Parent or other legally Authorized Representative, where applicable)

_____ (Signature of Witness) _____ (Title or Relationship to Individual)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

_____ (Date this authorization is revoked by Individual) _____ (Signature of Individual or legally authorized Representative)

Form Effective 7/1/2011