GEORGIA DEPARTMENT OF PUBLIC HEALTH

GEORGIA PRESCRIPTION DRUG MONITORING PROGRAM

AUTHORIZATION FOR RELEASE OF PATIENT PRESCRIPTION INFORMATION

Please provide the information requested below. (PRINT or TYPE) **Use full name, not initials.**

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

1. I hereby voluntarily authorize the Georgia Department of Public Health to disclose my prescription information from the Georgia Prescription Drug Monitoring Program data base to *(choose one)*:

   ME: _____

   THIS PERSON OR ENTITY: _____

2. The purpose of this disclosure is: _____

   _____

3. 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

_____ PRINT AUTHORIZED REPRESENTATIVE'S NAME *(if applicable)*

_____ AUTHORIZED REPRESENTATIVE'S SIGNATURE *(if applicable)*

_____ DATE

A copy of your current driver's license or other government-issued photo identification must be attached.

Email your completed form to **pdmp.public@dph.ga.gov** *or* mail to:

GEORGIA DEPARTMENT OF PUBLIC HEALTH
ATTN: Privacy Officer
200 Piedmont Avenue, SE East Tower Suite 486 Atlanta, GA 30334

[FORM GC-09015A]