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How to Complete Your Georgia HIPAA Authorization

Authorization for Release of Protected Health Information (45 C.F.R. § 164.508)

INSTRUCTIONS — KEEP FOR YOUR RECORDS. DO NOT ATTACH THIS PAGE TO YOUR DOCUMENT.

About this form. This form lets doctors, hospitals and insurers **share your medical information** with a family member, agent, attorney or anyone else you choose. It is often signed alongside a power of attorney or advance directive so your agent can get records quickly. Many providers, insurers and attorneys prefer a notarized authorization because it proves the signature is yours.

1. **Patient information (Section 1)**
   Enter your full legal name and date of birth exactly as on your medical records.
2. **Who discloses and who receives (Sections 2–3)**
   Choose any provider or list specific ones, then name the person or organization that may receive the records.
3. **What information (Section 4)**
   Check all records or limit by date or type. Mental health, substance use, HIV and genetic information are released only if you initial them in ink.
4. **Purpose and expiration (Sections 5–6)**
   Check the purpose and enter an end date or event, such as “conclusion of my claim.”
5. **Sign before a notary**
   Do **not** sign ahead of time. Bring a current government-issued photo ID. A personal representative signing for the patient should bring proof of authority.

Signing requirements: Signed by the patient or personal representative before a notary public.

After It’s Signed

- Give copies to the person receiving the records and to each provider or plan. Keep a copy for yourself.
- To revoke it, send a written revocation to each provider or plan that has it.

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Have questions about your HIPAA Authorization? To consult with an attorney, contact **Gavrilov & Brooks Law Firm** at **(916) 504-0529** or **www.gavrilovlaw.com**.

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

HIPAA Authorization • 45 C.F.R. § 164.508 • Georgia

1. PATIENT

Full legal name of patient

Date of birth

Address (street, city, state, ZIP)

Telephone

2. WHO MAY DISCLOSE MY INFORMATION

Any physician, hospital, clinic, laboratory, pharmacy, health plan, insurer or other covered entity that has provided treatment, services or payment for me

Only the following provider(s) or plan(s):

3. WHO MAY RECEIVE MY INFORMATION

Name of person or organization

Relationship

Address

Telephone

Name of second person or organization (optional)

Relationship

Address

Telephone

4. INFORMATION TO BE DISCLOSED

My entire medical record and billing records, including all of the categories below

Only: records dated from _____ to _____ and/or the following:

_____

Specially protected information. Information about the following is released ONLY if I initial it:

☐ Mental health records (psychotherapy notes require a separate authorization)

☐ Alcohol or drug abuse diagnosis or treatment records (including records protected by 42 C.F.R. Part 2)

☐ HIV/AIDS test results, diagnosis or treatment, and other sexually transmitted disease information

☐ Genetic testing information

5. PURPOSE

☐ At my request

☐ Continuing care, coordination of care, or management of my affairs by a family member or agent

☐ Insurance, benefits or claims

☐ Legal matters

☐ Other: _____

Patient's initials: _____

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6. EXPIRATION

This authorization expires on the following date or event (if none is given, it expires one year from the date signed):

Expiration date or event

7. MY RIGHTS

I understand that: (a) I may revoke this authorization at any time by giving written notice to the provider or plan that holds my information, except to the extent action has already been taken in reliance on it; (b) a provider or health plan may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization, except as permitted by law; (c) information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy rules; and (d) I am entitled to a copy of this authorization. A photocopy or electronic copy of this authorization is as valid as the original.

8. SIGNATURE

Sign only in front of the notary.

X _____ _____

Signature of patient or personal representative — Date

Printed name

If signed by a personal representative (such as a health care agent, guardian or parent of a minor), describe authority:

Authority to act for the patient

NOTARY ACKNOWLEDGMENT

State of Georgia
County of _____

On _____ (date), before me, the undersigned notary public, personally appeared _____ (name of signer), who proved to me on the basis of satisfactory evidence to be the person whose name is signed on this document and who acknowledged that he, she or they signed it voluntarily for its stated purpose.

_____ (Seal)

Signature of notary public

_____

Printed name of notary public

Notary Public, _____ County, Georgia

My commission expires: _____

Notary seal

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