

GHVP-20: Authorization for Release of Information

Name of Individual/Patient: DOB: Current Address: 1. I hereby voluntarily authorize the disclosure of my records/information: From: My community-based provider(s):					
			rel cor ac	The Georgia Housing Support The Georgia HUD-recogniz The deemed necesse my inform munity and/occess to housing The purpose Release my r Based Support	Department of Behavioral Health and Developmental Disabilities (DBHDD), port Program (HSP) specialty providers contracted by DBHDD, Department of Community Affairs (DCA), zed Continuums of Care within the state of Georgia, and their providers eccessary for the provision and coordination of my care, these agencies may nation to (1) contracted third parties; (2) referral partners, such as other or housing agencies who provide Community Based Support Services or g; and (3) potential and current landlords or leasing staff. The of the disclosure is to: The cords/information to participate in the Unified Referral Process for Community of the Services, which includes the Georgia Housing Voucher Program (GHVP), and fectively in the GHVP Housing Support Program according to the requirements of
			•		g providers, housing support services and healthcare providers to share my ecords with each other as required by the Program to effectively coordinate care.
3.	The informat	tion/records to be disclosed are:			
•	health assessments or other assessments as required for eligibility verification. • My Individualized Recovery/Resiliency Plan and associated documents.				
	_(initials)				
4. If applicable, this information may also include:					
	_(initials)	Substance use information.			
	_(initials)	HIV diagnosis and/or treatment for HIV / AIDS and any related conditions.			

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5. This authorization shall become effective immediately and shall remain in effect for the period necessary to complete all transactions on matters related to services provided to me, until and unless I elect to withdraw authorization for this release as outlined below. I understand that, except as set out in the paragraph directly below, information/records disclosed by this authorization may be re-disclosed by the recipient and no longer be protected by federal privacy regulations and other applicable state or federal laws. I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug use records that I authorize to be disclosed in this document may not be further re-disclosed without my written consent, except by a court order that complies with the preconditions set forth at 42 C.F.R. 2.61 et seq., or the other limited circumstances specifically permitted by 42 C.F.R. Part 2. Any individual that makes such a disclosure in violation of these provisions may be reported to the United States Attorney and be subject to criminal penalties. I understand that DBHDD or my healthcare provider will not condition my treatment, payment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information. I understand that, unless otherwise limited by state or federal regulation, and except to the extent that action has been taken based upon it, I may revoke this authorization at any time as shown in the space provided below. Individual Name Signature Time am/pm Date OR Signature of other person authorized to sign for Individual(check one): Print Name Date Time am/pm Guardian ___ Court-appointed Custodian of Minor Agent designated by Individual's advance directive Complaints and Additional Information: All complaints may be made to DBHDD and to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing with your DBHDD facility or program, or with your treatment provider or services provider under contract or agreement with DBHDD's Office of Constituent Services which maintains your protected health information at telephone (888) 785-6954, fax number (770) 408-5439, by mail to 2 Peachtree Street, NW, Suite 24-473 Atlanta, Georgia 30303, or email http://dbhdd.georgia.gov/office-constituent-services. You must state the basis for your complaint. Neither the facility, the provider, nor DBHDD will retaliate against you for filing a complaint. You may also obtain additional information about privacy practices from this contact person. You may also contact DBHDD's Privacy Officer by telephone at (404) 232-1174, fax number (404) 657-2173, or by mail to 2 Peachtree Street NW, Room 22.244, Atlanta Georgia, 30303-3142, for further information about the complaint process or about this notice. USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN I hereby revoke this authorization and will send written notice of my withdrawal of this authorization to the staff of the healthcare provider who is providing services to me, or to DBHDD's Privacy Officer at 2 Peachtree St. NW, Suite 22.250 Atlanta, GA 30303-3142. Date this authorization is revoked Time am/pm

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Signature of Individual or Legally Authorized Representative