Office of Disability
Services Ombudsman

_____
Name of Consumer/Individual

AUTHORIZATION FOR RELEASE OF INFORMATION

I do hereby authorize _____, its agents and/or employees to obtain from the Office of Disability Services Ombudsman, the following type(s) of information from my record (and any specific portion thereof):

_____

_____ (initial) I authorize the disclosure of my complaint filed with the Office of Disability Services Ombudsman on the following date_____.

I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if 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 the Office will not condition my treatment, or eligibility for any applicable benefits on whether I provide authorization for the requested release of information. I intend this document to be a valid authorization confirming all requirements of the Privacy Rule and state law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE):

☐ ONE YEAR

☐ PERIOD NECESSARY TO COMPLETE ALL TRANSACTIONS ON MATTERS RELATED TO SERVICES PROVIDED TO ME.

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 withdraw this authorization at any time by sending written notice of my withdrawal of this authorization to Office of Disability Services Ombudsman at 270 Washington Street, Suite 8087, Atlanta GA 30334.

Name: _____ Date: _____

Legal Representative: _____

Witness for the undersigned: _____

Signature: _____

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

_____ _____

Date authorization is revoked Signature of Consumer or Legally authorized Representative