

AAA Partners In Adoption, Inc.

5665 Hwy. 9, Suite 103-351
Alpharetta, GA 30004
Phone: (770) 844-2080

Melissa Clause
Executive Director

HIPAA RELEASE FORM

Name of Individual _____

Name of Individual _____

I hereby request and authorize: _____ GA Sexual Offender Registry _____
(Name of Agency Holding Information)

(Address)

to provide to: AAA Partners in Adoption, Inc., 5665 Hwy. 9, Suite 103-351, Alpharetta, GA 30004

The following type(s) of information from my records (and specific portions thereof):

Any and all records pertaining to GA Sexual Offender Registry

for the purpose of: _____ adoption _____

I understand the federal Privacy Rule (“HIPAA”) does not protect the privacy of information if disclosed, and therefore request that all information obtained for 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 of 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 and earlier expiration date here: _____
- one (1) year. (Date)
- the 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.*

(Signature of Individual) (Date)

(Signature of Witness) (Date)

(Signature of Individual) (Date)

(Title of relationship to Individual(s) (Date)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

(Signature of Individual)

(Date this Authorization is Revoked)

(Signature of Individual)

(Date this Authorization is Revoked)