AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize the Georgia Department of Community Health, Medicaid Agency to release any information from my file and the file of my minor child,_____ if applicable, including but not limited to, protected health information under HIPAA and information concerning our eligibility for benefits, medical records, bills, claims for benefits, benefits paid, insurance, and other third party liability coverage, as may be requested by:

a. Any party to the lawsuit entitled:

_____ v. _____

filed in the _____Court of _____

County, Civil Action No. _____

b. Other: _____

(Complete if applicable)

I certify that my correct recipient identification number is_____.

I hereby further certify that I am the parent or legal guardian of:

_____,

and that his/her correct recipient identification number is _____.

Dated this _____ day of _____, 20 ____.

This authorization expires two years from the date above.

_____
Signature

_____
Print Name/Relationship