Georgia Department of Behavioral Health
& Developmental Disabilities

Judy Fitzgerald, Commissioner

D·B·H·D·D

Region 1 Field Office

Intake Coordinator:
Katie King
770-781-6914

INFORMATION FOR APPLICANT

I want to extend a Welcome to you from the Region 1 Field Office. We appreciate your request for an Application for Developmental Disability Services. Enclosed with your application are several documents that should help you through the process of gathering information. This information needs to accompany your completed application. Included is the "Application for Developmental Disabilities Services", a List of Information for to you submit with your application packet, and a Release of Information form.

Completed Application Packets include the Application, and copies of the following documents (that pertain to you):

- Copy of Birth Certificate or other approved form of documentation to verify Lawful Presence
- Copy of Social Security card or Social Security number;
- Copy of Medicaid and/or Medicare card;
- Copy of Social Security Benefit information;
- Copy of Psychological Evaluations completed by school and/or private Psychologists *with signatures*;
- Copy of medical, diagnostic or testing report that has been completed by a doctor *with signatures;*
- Copies of reports *with signatures* describing your disabilities that may have been completed by schools you attended or by other services agencies, specifically copies of your IEP;
- Copy of guardianship documents (if applicable)

Once you have gathered the above information, please return to:

Department of Behavioral Health and Developmental Disabilities
Region 1 Field Office
Attn: Intake & Evaluation Unit 1230 Bald Ridge Marina Rd, Suite 800
Cumming, Georgia 30041

The application process for the Medicaid Waiver for Developmental Disabilities Services begins when our office receives your completed application packet which must include a copy of a Psychological Report(s) and Lawful Presence Verification Documents. Once we have had time to review the application packet submitted, staff from the Region 1 Field Office will be in touch with you about the next step in the process. If you have any questions or need help with filling out the application, don't hesitate to contact our office.

Please feel free to call the Region 1 Field Office at (678) 947-2818, if you have any questions.

Respectfully,

Elise Beumer, M.S., LPC

Elise Beumer, LPC
Regional Services Administrator for Developmental Disabilities

Georgia Department of Behavioral Health
& Developmental Disabilities

Judy Fitzgerald, Commissioner

D·B·H·D·D Region 1 Field Office

NEED FOR DOCUMENTATION

WHAT WE NEED: Determining someone's eligibility for services based on a developmental disability can be particularly complicated. Examples of the kinds of records that are most helpful in determining eligibility are:

- Psychological Evaluations
- Individualized Education Plans (IEPs) and other school-based assessments
- Treatment notes that contain diagnoses of Intellectual Disabilities, Autism or a similar disability
- Professional observations and reports concerning level of intellect (IQ) and adaptive behavior/daily living skills

WHY WE NEED IT: We do not want to unfairly deny people of benefits they deserve or make the intake process excessively long and burdensome. But the only way we can establish an individual's eligibility for services is through records that describe how the person was thinking, behaving, and performing as a child or adolescent These records may be difficult to find and obtain but they are irreplaceable sources of information.

WHERE TO FIND IT: The following places may have the kind of information that could help us to establish the existence of a developmental disability:

- Schools
  - Where did the applicant attend school?
  - Was there a special education program- an Individualized Education Program (IEP)?
  - Are there transcripts showing classes attended?
  - Psychological or Psycho-Educational Assessments (prior to age 18 for an Intellectual Disability and/or the age of 22 for a Closely Related Condition)
- Job Training or Vocational Rehabilitation Programs
  - Has the applicant ever tried to get help in finding work or applied for a work training program?
- Social Security Administration Offices
  - Has the applicant ever applied for disability benefits? What county was the applicant living in when those benefits were applied for?

HOW TO GET IT: There are two ways to get the kinds of records that we need.

1. The applicant or guardian can request the records directly and then send the copies to the Intake and Evaluation Office. Sometimes this method gets the fastest response and it is required for Social Security records.

2. Complete and sign a separate consent form for each individual and/or agency that should be given permission to release information to the Intake and Evaluation Office. Once received in the Intake and Evaluation office, a letter will be sent to the agency specified requesting a copy of the records on the applicant's behalf.

3. . Please be sure to send in *"signed"* copies of records.

DBHDD

Instructions for Intellectual/Developmental Disabilities Services Application

Please use this guide to help you through the application process. Check off each step as it is completed. Call your field office (listed below) if you need assistance.

	1. Complete the two-page Application for Intellectual/Developmental Disabilities Services.
	2. Please submit copies of the following documents along with the application:
	a. Psychological report that includes IQ score, assessment of Autism Spectrum Disorder (if applicable), and adaptive skills testing, preferably completed prior to the age of 18 for a person with intellectual disability or 22 for a person with a closely-related condition
	b. Proof of citizenship (birth certificate, passport, or permanent resident card)
	c. Copy of Social Security card or Social Security number
	d. Copy of Medicaid and/or Medicare card
	e. Copy of Social Security benefit information
	f. Copy of guardianship documents (if applicable)
	g. Copy of reports describing the disability completed by schools attended or by other service agencies (e.g., IEP)
	h. Authorization for Release of Information (requires signature) if you would like us to request records from a particular agency
	i. Notice of Privacy Practices (requires signature)
	3. Return the application and requested documents to your regional field office.

Once we have determined that a completed application packet has been received by our office, we will contact you and/or your family participant/representative to schedule a screening assessment meeting within 14 business days.

Region 1 Field Office
Intake & Evaluation Unit
1230 Bald Ridge Marina Road
Suite 800
Cumming, GA 30041
678-947-2818 or 877-217-4462
Fax: 678-947-2817

Region 2 Field Office
Intake & Evaluation Unit
3405 Mike Padgett Hwy, Bldg 3
Augusta, GA 30906
706-792-7741 or 877-551-4897
Fax: 706-792-7740

Region 3 Field Office
Intake & Evaluation Unit
3073 Panthersville Rd, Bldg 10
Decatur, GA 30034
404-244-5050 or 404-244-5056
Fax: 404-244-5179

Region 4 Field Office
Intake & Evaluation Unit
P.O. Box 1378
Thomasville, GA 31799-1378
229-225-5099 or 877-683-8557
Fax: 229-227-2918

Region 5 Field Office
Intake & Evaluation Unit
1915 Eisenhower Drive, Bldg 7
Savannah, GA 31406
912-303-1649 or 800-348-3503
Fax: 912-351-6309

Region 6 Field Office
Intake & Evaluation Unit
3000 Schatulga Road, Bldg 4
Columbus, GA 31907-2435
706-565-7835 or 877-565-8040
Fax: 706-565-3565

Georgia Department of Behavioral Health and Developmental Disabilities

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Application for Intellectual/Developmental Disabilities Services

Personal Details

All fields marked * are required

First Name * | M.I. | Last Name *

Suffix (select one)
☐ JR. ☐ SR. ☐ II ☐ III

Maiden or Birth Surname | Preferred Name

Date of Birth (MMDDYYYY) *

Gender (select one) *
☐ Male ☐ Female
☐ Transgender Male to Female
☐ Transgender Female to Male
☐ Other/Unknown

Marital Status (select one) *
☐ Single ☐ Separated
☐ Married ☐ Widowed
☐ Divorced ☐ Unknown/Refused
☐ Partnered

Race (select one) *
☐ American Indian/Alaskan Native
☐ Black/African American
☐ White/Caucasian
☐ Asian
☐ Multiracial
☐ Other Single Race
☐ Unknown/Refused

Hispanic/Latino Origin (select one) *
☐ Yes
☐ No
☐ Unknown/Refused

SSN * ☐ SSN Not Available ☐ Medicare # | Medicaid # or Application Date

Current Living Situation _____

Primary Phone Number * | Secondary Phone Number

Email Address | Confirm Email Address

Street Address * | Apt/Unit/Suite or Other Address | City *

State * | Zip * | County of Residence *

Is the Applicant Lawfully Present in the United States?
☐ Yes ☐ No ☐ N/A (e.g. individual is under 18) ☐ Unknown/Refused

Is the Applicant a Veteran?
☐ Yes ☐ No ☐ Unknown/Refused

☐ Check here if mailing Address is same as above

Mailing Street Address or PO Box | Mailing Apt/Unit/Suite or Other Address | Mailing City

Mailing State | Mailing Zip | County of Residence

PRIMARY CONTACT DETAILS

Primary Contact First Name | M.I. | Primary Contact Last Name | Suffix (select one) ☐ JR. ☐ SR. ☐ II ☐ III

Relation to Applicant | Primary Contact Age | Email Address

Primary Phone Number | Secondary Phone Number

Street Address | Apt/Suite or Other Address Info

City | State | Zip | County of Residence

Georgia Department of Behavioral Health and Developmental Disabilities

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Application for Intellectual/Developmental Disabilities Services

Legal Status and Guardian

All fields marked * are required

What is the legal status of the Applicant?

- ☐ Competent
- ☐ Emancipated
- ☐ Legally Incompetent: Documentation Required*
- ☐ Minor
- ☐ Unknown

**It is mandatory to fill in Legal Guardian details for individuals with a Court appointed guardian.*
Note: Guardianship Order from a Georgia Probate Court must be attached

Is Legal Guardian a *

☐ Person ☐ Agency

Legal Guardian or Caseworker First Name *

Legal Guardian Caseworker Last Name *

Suffix (select one)
☐ JR. ☐ SR. ☐ II ☐ III

M.I.

Legal Guardian Email

Relationship to Applicant (select one) *

- ☐ Case Worker
- ☐ Child
- ☐ Counselor/Teacher
- ☐ Friend
- ☐ Grandparent
- ☐ In-Law Relative
- ☐ Neighbor
- ☐ Other Family Member
- ☐ Parent
- ☐ Roommate
- ☐ School
- ☐ Sibling
- ☐ Spouse/Significant Other
- ☐ Substitute Decision-Maker
- ☐ Other

Legal Guardian Phone Number *		Legal Guardian Phone Extension

☐ Check here if Legal Guardian's Address is the same as the Applicant

Legal Guardian Street Address or PO Box

Apt/Unit/Suite or Other Address

City

State

Zip

County of Residence

Georgia Department of Behavioral Health and Developmental Disabilities

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Application for Intellectual/Developmental Disabilities Services

Communication

All fields marked * are required

English Proficiency (select one)

- ☐ Very Well
- ☐ Well
- ☐ Not Well
- ☐ Not at All
- ☐ Unknown/Refused

Does the Applicant prefer to speak or use a language other than English? *

☐ Yes ☐ No ☐ Unknown/Refused ☐ Preferred Language _____

What mode of communication does the Applicant utilize? (select all that apply) *

- ☐ Communicates verbally (regardless of proficiency)
- ☐ Communication Aids (any type of device used for communication)
- ☐ American Sign Language (ASL)
- ☐ Other Manual Communication (cued speech; gestures; signed exact English; other signed languages; etc.)
- ☐ Other Communication

Preferred Mode of Communication (select an option) *

- ☐ Communicates verbally (regardless of proficiency)
- ☐ Communication Aids (any type of device used for communication)
- ☐ American Sign Language (ASL)
- ☐ Other Manual Communication (cued speech; gestures; signed exact English; other signed languages; etc.)
- ☐ Other Communication

Hearing

Is the Applicant deaf or does the Applicant have serious difficulty hearing? *

☐ Yes ☐ No ☐ Unknown/Refused

Is there indication from sources other than the Applicant (e.g. third-party report; interviewer's observation; medical records, etc.) that the Applicant has hearing loss?

☐ Yes ☐ No ☐ Unknown/Refused

Vision

Is the Applicant blind or does the Applicant have serious difficulty seeing, even when wearing glasses/contacts? *

☐ Yes ☐ No ☐ Unknown/Refused

Georgia Department of Behavioral Health and Developmental Disabilities

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Application for Intellectual/Developmental Disabilities Services

IDD Diagnosis

All fields marked * are required

Does the Applicant have a confirmed Intellectual and/or Developmental Disability Diagnosis?

☐ Yes ☐ No ☐ Unknown/Refused

Referral/Resources

Select Applicant Referral Source * _____

Referral Source Name * _____

Current Resources Selection *

- ☐ Adoption Assistance
- ☐ CAPS (Subsidized Child Care Assist)
- ☐ CBAY (Comm Based Alternatives for Youth
- ☐ CCSP (Comm Care Services Prog)
- ☐ Deeming Waiver (Katie Beckett)
- ☐ Employment
- ☐ Food Stamps (SNAP)
- ☐ FQHC (Federally Qualified Health Ctr)
- ☐ GAPP (Georgia Pediatric Prog Waiver)
- ☐ HIPP (Health Insurance Premium Payment Prog)
- ☐ Housing Assistance (Section 8, HPRP)
- ☐ ICWP (Independent Care Waiver Prog)
- ☐ MAO (Medical Assistance Only)
- ☐ Medicaid
- ☐ Medicare
- ☐ PASS (Plan for Achieving Self Sup)
- ☐ PeachCare for Kids
- ☐ Private Insurance
- ☐ Railroad Benefits
- ☐ SOURCE (Source Options Using Resources in a Comm Environment
- ☐ SSDI
- ☐ SSI
- ☐ TANF (Temp Assist for Needy Families)
- ☐ Ticket to Work
- ☐ Veterans Assistance/Benefits
- ☐ Vocational Rehabilitation
- ☐ Other

Applicant's Monthly Gross Income *

_____

Physician Details

All fields marked * are required

Physician Name _____ Email _____

Street Address/PO Box

_____

Apt/Unit/Suite or Other Address Info

_____

City _____ State _____ Zip _____

Phone Number _____ Phone Extension _____ Fax Number _____

Georgia Department of Behavioral Health and Developmental Disabilities

Application for Intellectual/Developmental Disabilities Services

Application Supporting Documents

All fields marked * are required

Please ATTACH supporting documentation to verify Medicaid eligibility, lawful presence, and a qualifying diagnosis or condition. An application is complete for DBHDD review when required documents are received by mail or documents are attached to accompany the web application.

Document Type

- ☐ Birth Certificate or Permanent Resident Card *
- ☐ Developmental Evaluation
- ☐ Medicaid *
- ☐ Medicare Card (if applicable) *
- ☐ Other Medical or Diagnostic Reports
- ☐ Psychological Evaluation *
- ☐ School IEP Report *
- ☐ School Transcript
- ☐ Social Security Benefit Letter *
- ☐ Social Security Card *
- ☐ Vocational/Support Employment Records
- ☐ Release of Information and/or Guardianship Documents

If the applicant does not have social security card, Medicaid or Medicare, documentation of lawful presence can include: a birth certificate or unexpired permanent resident card. A description of documentation of lawful presence can be found at: http://www.mmis.georgia.gov. To access this information, please point to the 'provider information' menu and select 'provider manuals'. The criteria can be found in the 'Comprehensive Supports Waiver Program Part II manual.'

Application Signature

All fields marked * are required

Last Name _____ First Name _____ M.I. _____ Date _____

Application Completed By

☐ Applicant ☐ Guardian ☐ Family Member ☐ Other (agency, etc.) _____

Printed Name

_____

Please indicate the preferred method of contact

☐ Email Address ☐ Phone

Email Address _____ Primary Phone Number _____

Georgia Department of Behavioral Health
& Developmental Disabilities

Judy Fitzgerald, Commissioner

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Region 1 Field Office

IMPORTANT INFORMATION REGARDING THE FOLLOWING DOCUMENTS PERTAINING TO GUARDIANSHIP STATUS.

If an "Individual" is applying for services and age 18 or over and there are no Legal Letters of Guardianship Documents for the State of Georgia, that "Individual" must sign (or make their mark) and initial the forms where indicated.

Authorizations for Release of Information (ROI) - ***Please see the sample documents and fill out accordingly.***

Notice of Privacy Practices Form (NPP)

Please contact the office if you have any questions – 678-947-2818

Thank you.

SAMPLE

Georgia Department of Behavioral Health & Developmental Disabilities
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If no legal guardianship records from St. of GA, with this form, the individual gives permission for someone to speak their behalf.

John Smith
Name of Individual/Consumer/Patient/Applicant
3/4/1985
Date of Birth AND/OR Social Security Number

AUTHORIZATION FOR RELEASE OF INFORMATION – STANDARD REQUEST

I hereby authorize the disclosure of records/information

From: DBHDD Region 1 Field Office
(Name of health care provider holding the information - releasing agency)
1230 Bald Ridge Marina Road, Suite 800, Cumming, GA 30041 678-947-2818 FAX: 678-947-2817
(Address) (Phone/Fax)

To: *Name of Family Member and/or: Other Relative, Teacher, Translator, Friend, Social Worker, etc.*
(Name of Person or Agency to whom information should be given - requesting agency)
(Address) (Phone/Fax)

JS Initials — I authorize the following information from my records (and any specific portion thereof): ***All that pertain to the eligibility determination for the Medicaid NOW COMP Waiver***

JS Initials — I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below). If I am a minor, my parent/guardian/court-ordered custodian and I **BOTH** must initial here in order for this information to be released.

Initials

JS Initials — I authorize the disclosure of information, if any, concerning testing for HIV (Human Immunodeficiency Virus) and/or treatment for HIV or AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.

The above disclosure of information is for the purpose of: ***Medicaid NOW COMP Waiver Eligibility***

1. *I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*
2. *I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to 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.*
3. *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.*
4. *I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)*

Check Box >> ☐ one (1) year OR ☐ 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 revoke this authorization at any time as shown in the space below.

X	John Smith	2/18/19
Signature of Individual/Consumer/Patient/Applicant	**Print Name**	**Date**
NOT APPLICABLE XXXXXXXXXXXX	***N/A***	***N/A***
OR Signature of other person authorized to sign for Individual (check one):	**Print Name**	**Date**
☐ **Parent** ☐ **Guardian** ☐ **Court-appointed Custodian of Minor**		
☐ **Agent designated by Individual's advance directive**		

Georgia Department of Behavioral Health & Developmental Disabilities

D·B·H·D·D

Name ofIndividual/Consumer/Patient/Applicant

Date of Birth AND/OR Social Security Number

AUTHORIZATION FOR RELEASE OF INFORMATION – STANDARD REQUEST

I hereby authorize the disclosure of records/information

From: GA Dept. of Behavioral Health and Developmental Disabilities 678-947-2818
(Name of health care provider holding the information - releasing agency)
1230 Bald Ridge Marina Rd Suite 800, Cumming GA 30041 Fax 678-947-2817
(Address) (Phone/Fax)

To: _____
(Name of Person or Agency to whom information should be given - requesting agency)

_____
(Address) (Phone/Fax)

_____ I authorize the following information from my records (and any specific portion thereof):
Initials

_____ I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below). If I am a minor,
Initials my parent/guardian/court-ordered custodian and I **BOTH** must initial here in order for this information to be released.

_____
Initials

_____ I authorize the disclosure of information, if any, concerning testing for HIV (Human Immunodeficiency Virus)
Initials and/or treatment for HIV or AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.

The above disclosure of information is for the purpose of:

Medicaid NOW COMP Waiver Eligibility and Processes

1. *I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*
2. *I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to 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.*
3. *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.*
4. *I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)*

☐ one (1) year OR ☐ 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 revoke this authorization at any time as shown in the space below.

Signature of Individual/Consumer/Patient/Applicant	**Print Name**	**Date**	**Time am/pm**
OR Signature of other person authorized to sign for Individual(check one):	**Print Name**	**Date**	**Time am/pm**

☐**Parent** ☐**Guardian** ☐**Court-appointed Custodian of Minor**

☐**Agent designated by Individual's advance directive**

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** **Signature of Individual or Legally Authorized Representative**

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.

Signature of Individual or Legally Authorized Person Date Time am/pm

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NOTICE OF NONDISCRIMINATION:

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. DBHDD does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. To communicate effectively with us, DBHDD provides to people with disabilities free aids and services such as interpreters; and written information in other formats (large print, audio, accessible electronic formats). To communicate effectively with us, DBHDD provides to people whose primary language is not English free language services such as: interpreters and information written in other languages. If you need these services, contact Constituent Services at 404-657-5964 or 888-785-6954.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (404.657.5964 or 888.785.6954)
ध् य् न द�: य�द आप �ह द� बोलत् ह� त् ो ो आपक् �लए म् त म� भ ष् सह् यत स व् ए उपलब् ध ह�। (404.657.5964 or 888.785.6954)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (404.657.5964 or 888.785.6954)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (404.657.5964 or 888.785.6954)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로이용하실 수 있습니다. (404.657.5964 or 888.785.6954) 번으로 전화해주십시오.
ВНИМАНИЕ: Если вы говорите на русском языке, то вамдоступны бесплатные услуги перевода. Звоните (404.657.5964 or 888.785.6954).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (404.657.5964 or 888.785.6954).
ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم (404.657.5964 or 888.785.6954) اتصل
�ુચ ના: જો તમે �જુ રાતી બોલતા હો, તો ો ્ ન:�ન્ક ભાષા સહાય સેવાઓ તમારા માટ� ઉપલબ્ધ છે. ફોન કરો (404.657.5964 or 888.785.6954).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (404.657.5964 or 888.785.6954).
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (404.657.5964 or 888.785.6954).
توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما با .باشد می فراهم (404.657.5964 or 888.785.6954)
ማስታወሻ:የሚናገሩትቋንቋአማርኛከሆነየትርጉምእርዳታድርጅቶች፣በነጻሊያግዝዎትተዘጋጀተዋል፡ወደሚከተለው ቁጥርይደውሉ (404.657.5964 or 888.785.6954)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (404.657.5964 or 888.785.6954)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 (404.657.5964 or 888.785.6954). まで、お電話にてご連絡ください。

SAMPLE

Georgia Department of Behavioral Health & Developmental Disabilities

D·B·H·D·D

John Smith
Name of Individual/Consumer/Patient/Applicant
3/4/1985
Date of Birth AND/OR Social Security Number

AUTHORIZATION FOR RELEASE OF INFORMATION – STANDARD REQUEST

I hereby authorize the disclosure of records/information

From: *The agency/organization/person that you want us to receive information from*
(Name of health care provider holding the information - releasing agency)
(Address) (Phone/Fax)

To: DBHDD Region 1 Field Office, 1230 Bald Ridge Marina Road, Suite 800, Cumming, GA 30041
(Name of Person or Agency to whom information should be given - requesting agency) 678-947-2818 Fax: 678-947-2817
(Address) (Phone/Fax)

Initial All

____ Initials I authorize the following information from my records (and any specific portion thereof): *Medical Records, and/or Psychological/Psychoeducational Evaluations, IEPs, Transcripts*

____ Initials I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below). If I am a minor, my parent/guardian/court-ordered custodian and I **BOTH** must initial here in order for this information to be released.

____ Initials

____ Initials I authorize the disclosure of information, if any, concerning testing for HIV (Human Immunodeficiency Virus) and/or treatment for HIV or AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.

The above disclosure of information is for the purpose of: *Medicaid NOW COMP Waiver Eligibility*

1. *I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*
2. *I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to 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.*
3. *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.*
4. *I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)*

Check Box>>>> ☐ one (1) year OR ☐ 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 revoke this authorization at any time as shown in the space below.
If the indivdual is over 18 and there are no legal guardianship records from the State of GA, the individual must sign and intial where indicated.

Signature of Individual/Consumer/Patient/Applicant	**Print Name**	**Date**
OR Signature of other person authorized to sign for Individual (check one): ☐ **Parent** ☐ **Guardian** ☐ **Court-appointed Custodian of Minor** ☐ **Agent designated by Individual's advance directive**	**Print Name**	**Date**

Georgia Department of Behavioral Health & Developmental Disabilities

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Name ofIndividual/Consumer/Patient/Applicant

Date of Birth AND/OR Social Security Number

AUTHORIZATION FOR RELEASE OF INFORMATION – STANDARD REQUEST

I hereby authorize the disclosure of records/information

From: _____
(Name of health care provider holding the information - releasing agency)

_____
(Address) (Phone/Fax)

To: Dept of Behavioral Health & Developmental Disabilities PH: 678-947-2818
(Name of Person or Agency to whom information should be given - requesting agency)

1230 Bald Ridge Marina Rd, Ste. 800, Cumming, GA 30041 Fax:678-947-2817
(Address) (Phone/Fax)

____ I authorize the following information from my records (and any specific portion thereof):
Initials

____ I authorize the disclosure of alcohol or drug abuse information, if any. (Please see paragraph 2 below). If I am a minor,
Initials my parent/guardian/court-ordered custodian and I **BOTH** must initial here in order for this information to be released.

____
Initials

____ I authorize the disclosure of information, if any, concerning testing for HIV (Human Immunodeficiency Virus)
Initials and/or treatment for HIV or AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.

The above disclosure of information is for the purpose of:

Medicaid NOW COMP Waiver Eligibility

1. *I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws (except as set forth in paragraph 2 below).*
2. *I understand that, pursuant to 42 C.F.R Part 2, alcohol and drug abuse records that I authorize to be disclosed pursuant to 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.*
3. *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.*
4. *I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and State law, and understand that my authorization will remain in effect for: (PLEASE CHECK ONE)*

☐ one (1) year OR ☐ 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 revoke this authorization at any time as shown in the space below.

Signature of Individual/Consumer/Patient/Applicant	**Print Name**	**Date**	**Time am/pm**
OR Signature of other person authorized to sign for Individual(check one):	**Print Name**	**Date**	**Time am/pm**

☐**Parent** ☐**Guardian** ☐**Court-appointed Custodian of Minor**

☐**Agent designated by Individual's advance directive**

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**	**Signature of Individual or Legally Authorized Representative**

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.

Signature of Individual or Legally Authorized Person	Date Time am/pm

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NOTICE OF NONDISCRIMINATION:

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. DBHDD does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. To communicate effectively with us, DBHDD provides to people with disabilities free aids and services such as interpreters; and written information in other formats (large print, audio, accessible electronic formats). To communicate effectively with us, DBHDD provides to people whose primary language is not English free language services such as: interpreters and information written in other languages. If you need these services, contact Constituent Services at 404-657-5964 or 888-785-6954.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (404.657.5964 or 888.785.6954)
ध् य् न द�: य�द आप �ह् द� बोलत् ह� त् ो आपक् �लए म् त म� भ ष् सह् यत स व् ए उपलब् ध ह�। (404.657.5964 or 888.785.6954)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (404.657.5964 or 888.785.6954)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (404.657.5964 or 888.785.6954)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로이용하실 수 있습니다. (404.657.5964 or 888.785.6954) 번으로 전화해주십시오.
ВНИМАНИЕ: Если вы говорите на русском языке, то вамдоступны бесплатные услуги перевода. Звоните (404.657.5964 or 888.785.6954).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (404.657.5964 or 888.785.6954).
ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل (404.657.5964 or 888.785.6954)
�ચુ ના: જો તમે �જુ રાતી બોલતા હો, તો ો ન:�લ્ક ભાષા સહાય સેવાઓ તમારા માટ� ઉપલબ્ધ છે. ફોન કરો (404.657.5964 or 888.785.6954).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (404.657.5964 or 888.785.6954).
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (404.657.5964 or 888.785.6954).
توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما با باشد می فراهم (404.657.5964 or 888.785.6954)
ማስታወሻ:የሚናገሩትቋንቋአማርኛከሆነየትርጉምእርዳታድርጅቶች፣በነጻሊያግዝዎትተዘጋጀተዋል፡ወደሚከተለው ቁጥርይደውሉ (404.657.5964 or 888.785.6954)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (404.657.5964 or 888.785.6954)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 (404.657.5964 or 888.785.6954). まで、お電話にてご連絡ください。

Georgia Department of Behavioral Health & Developmental Disabilities NOTICE OF PRIVACY PRACTICES FORM Per DBHDD Policy 23-101 Facility/Program/Hospital Name: DBHDD Region 1 Field Office Address, City, State, Zip: 1230 Bald Ridge Marina Rd, Ste. 800, Cumming, GA 30041 Contact numbers: 678-947-2818 Fax: 678-947-2817	

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY THE DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES (DBHDD) AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. It is provided to you under the Health Insurance Portability and Accountability Act of 1996 and related federal regulations (together referred to as "HIPAA") and provides some additional information about other federal and state confidentiality protections. If you have questions about this Notice please contact the facility where you receive services (your treatment provider or services provider) or DBHDD's Privacy Officer at the address below.

DBHDD is an agency of the State of Georgia responsible for certain programs which deal with medical, mental health, developmental disabilities, addictive disease, and other confidential information. DBHDD must comply with strict requirements of federal and state laws regarding confidential information. For situations where stricter disclosure requirements do not apply, this Notice of Privacy Practices describes how DBHDD may use and disclose your "protected health information" for treatment, payment, health care operations, and certain other purposes. This notice also describes your rights regarding your protected health information. **Protected Health Information** is information that may personally identify you and relates to your past, present or future physical or mental health or condition and related health care services, and payment for services. DBHDD is also required to provide you this Notice of Privacy Practices, and to abide by its terms. DBHDD may change the terms of this notice at any time. A new notice will be effective for all protected health information that DBHDD maintains at the time of issuance. DBHDD will provide you with any revised Notice of Privacy Practices by posting copies at its facilities, publication on DBHDD's website, in response to a telephone or facsimile request to the Privacy Officer, or in person at any facility where you receive services.

1. Your Rights: The following is a statement of your rights about your protected health information and how you may exercise these rights. If you have a court-appointed guardian, your guardian may exercise these rights for you; if you are a minor, your parent or court-appointed custodian may exercise these rights for you; your healthcare agent in a valid advance directive may exercise these rights for you if your advance directive says so. To exercise any of these rights, you may contact the staff person named in Section 7 below, at your treatment provider's location, or your treatment provider's HIPAA Coordinator.

a. You have the right to inspect and copy your Protected Health Information: You may inspect and obtain a copy of protected health information about you for as long as DBHDD maintains the protected health information. This information includes medical and billing records and other records DBHDD uses for making medical and other decisions about you. A reasonable, cost-based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy information compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or protected health information that is subject to a federal or state law prohibiting access to such information. While you are hospitalized, your physician may restrict your right to review your records if it may endanger your life or physical safety. If your protected health information was obtained or created in the course of research that includes treatment, your right to access that protected health information may be restricted while the research is in progress, if you agreed to this restriction in advance.

b. You have the right to request restriction of your Protected Health Information: You may ask DBHDD not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations, and not to disclose protected health information to family members or friends who may be involved in your care. Your request must be in writing, and it must state the specific restriction you are requesting and to whom you want the restriction to apply. DBHDD is not required to agree to a restriction you request, and DBHDD may not prevent disclosures to the Secretary of Health and Human Services or any disclosure that is required by law. If DBHDD believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted, except as required by law. If DBHDD does agree to your request, DBHDD may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. DBHDD must agree to a restriction if you request to restrict

disclosure of your protected health information to a health plan when: (1) the disclosure is for the purpose of payment or health care operations and is not otherwise required by law; AND (2) the protected health information is about only a health care item or service for which you, or a person other than a health plan on your behalf, have paid DBHDD in full.

c. You have the right to request to receive confidential communications from us, including billing and payment information, by alternative means or at an alternative location: If you request it in writing, DBHDD will agree to reasonable requests for alternative means for sending confidential information to you. Your request must tell us how or where you wish to be contacted, or provide an alternative means of payment if necessary. DBHDD will not ask you the reason for your request.

d. You have the right to request amendment of your Protected Health Information: If DBHDD created your protected health information; you may request an amendment of that information for as long as it is kept by or for DBHDD. DBHDD may deny your request, and if it does so will provide information as to any further rights you may have about the denial.

e. You have the right to receive an accounting of certain disclosures DBHDD has made of your Protected Health Information: You have the right to receive legally specified information about disclosures of your protected health information that DBHDD made in the six (6) years before your request, with certain exceptions, restrictions and limitations. This right applies only to disclosures for purposes other than treatment, payment or healthcare operations, and does not apply to any disclosures DBHDD made to you; to family members or friends or representatives, as defined in the Georgia Mental Health Code, who are involved in your care; to anyone based on written authorization by you (or by your guardian, parent or court-appointed custodian, or healthcare agent as applicable); or for national security, intelligence or notification purposes.

f. Notice of Breach. DBHDD has put in place reasonable policies and procedures to protect the privacy and security of your protected health information. DBHDD will notify you, as required by law, if there is an unauthorized acquisition, access, use or disclosure of your protected health information. The law may not require notice to you in all cases.

f. You have the right to obtain a paper copy of this notice from DBHDD, upon request at any time. You can also find this Notice on our website, http://dbhdd.georgia.gov/.

2. Uses and Disclosures of Protected Health Information: DBHDD, its administrative and clinical staff and others involved in your care and treatment, may use and disclose your protected health information to provide health care services to you, and in obtaining payment of your health care bills.

a. Treatment: DBHDD may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services, including coordination of your health care with a current, former, or identified future third party provider. For example, we may disclose your treatment or services plan to a health care professional who is treating you, or who is named in your Individualized Recovery Plan or Individualized Service Plan and will be your provider upon your discharge or transition; to a jail or corrections facility if you are under criminal charges and discharged to jail or corrections; or to another health care provider such as a specialist or laboratory.

b. Payment: DBHDD may use and disclose your protected health information to obtain payment for your health care services. For example, your health insurance plan may require protected health information about you to make a determination of eligibility or coverage, or to review services provided to you for medical necessity, before your health insurance plan approves or pays for your health care services. Your protected health information may be shared with third party "business associates" who perform various activities that assist us in obtaining payment; business associates and any subcontractors they may have are also required by law to keep your protected health information confidential.

c. Health Care Operations: DBHDD may use or disclose your protected health information for the business activities of DBHDD, including, for example, but not limited to, quality assessment activities, employee review activities, training, and licensing activities. We may also use your protected health information to contact you about appointments or for other operational reasons. DBHDD may also use or disclose your protected health information to third party "business associates" who perform various activities that assist us in providing services to you. Some examples of our business associates might include, but are not limited to, the Georgia Collaborative ASO for care management and the Georgia Crisis Access Line for access to crisis or non-crisis services and referrals. Business associates and any subcontractors they may have are also required by law to keep your protected health information confidential.

d. Your Representatives: If you are in a DBHDD hospital, you are allowed to name a representative to receive certain protected health information about you, or DBHDD must name a representative for you if you do not name one. DBHDD will also name a second representative for you, according to Georgia law. DBHDD is not required to seek your authorization in order to inform your representatives of your admission to the hospital, and of your discharge. Unless there is an emergency, you will have a chance to object to other disclosures to your representatives about the development of your Individualized Recovery Plan (IRP) for behavioral health treatment or services, your treatment under the IRP, and certain substantial changes to your IRP.

3. You May Authorize or Object To Certain Other Permitted or Required Uses and Disclosures of Your Protected Health Information: Your protected health information, including clinical records of treatment for mental illness or addictive disease or services relating to developmental disability, is protected by confidentiality under state law. DBHDD is permitted to make certain disclosures described in Section 2 above and in Sections 4 and 5 below, without your authorization or opportunity to object. Other uses and disclosures of your protected health information will be made only if DBHDD has written authorization signed by you (or if you have one, your guardian, parent or legal custodian if you are a minor, or your healthcare agent if you have an advance directive currently in effect). Your written authorization may be revoked at any time. DBHDD will not be able to retract any disclosures of your protected health information that were previously authorized. DBHDD may disclose all or part of your protected health information when authorized in writing.

a. Confidentiality of Alcohol and Drug Abuse Patient Records: The confidentiality of patient records which disclose any information identifying you as an alcohol or drug abuser is protected by federal law and regulations. This information generally will not be disclosed unless you consent in writing, the disclosure is allowed by a court order, or the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Violation of these federal laws and regulations by the facility, treatment or service provider, or DBHDD, is a crime. You may report violations to appropriate authorities in accordance with the federal regulations. Federal regulations do not protect any information about a crime committed by you either at a facility or program or against any person who works at a facility or program, or information about any threat to commit such a crime. Federal regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State agency and local law enforcement authorities.

b. HIV or AIDS Confidential Information: Although HIV infection is required to be reported or disclosed in some circumstances under state law, AIDS confidential information, including HIV status or testing information is generally confidential under state law. Other than required disclosures listed at 4.d. below, DBHDD will not disclose AIDS confidential information without your authorization.

c. Psychotherapy Notes: Authorization is required for use or disclosure of psychotherapy notes not maintained in your medical record. This authorization may not be required for disclosure of psychotherapy notes about you to the criminal court and attorneys if a DBHDD hospital or its outpatient team is evaluating your mental status to go to trial on criminal charges, or evaluating your mental status at the time you committed a criminal act.

d. Health Information Networks or Exchanges: Health information exchanges allow health care providers, including DBHDD, to share and receive health information about individuals receiving our services, which helps in the coordination of your care. DBHDD participates in health information networks that can make your protected health information available electronically to your other providers who are members of the networks. For individuals who have signed an authorization to allow sharing of their protected health information (including alcohol or drug treatment or services information they may have) with their other providers, DBHDD shares protected health information electronically with those other Health Information Exchange members through the Georgia Health Information Network (GaHIN).

e. Complaints About Your Treatment: If DBHDD receives a complaint about your treatment or services, such as from your representative or family member, DBHDD will not disclose your protected health information to that person in response to the complaint, unless you have signed an authorization for us to disclose your protected health information.

f. Marketing and Fundraising: If DBHDD wishes to use your protected health information for fundraising (for instance, to put your name on a mailing list for requesting a donation to patient benefit funds), or for marketing (for instance, to advertise our treatments and services by using your protected health information) we will first request your written authorization.

4. Permitted or Required Uses and Disclosures Without Your Authorization or Opportunity to Object: DBHDD may use or disclose your protected health information without your authorization when the law allows it or requires it.

a. Persons Involved In Your Care: DBHDD can use or disclose your protected health information without your authorization, to your court-appointed guardian, if you have a guardian; to your parent or court-appointed custodian if you are a minor, or to your healthcare agent that you have named in an advance directive that is currently in effect.

b. Regarding Your Health Care: DBHDD can use or disclose your protected health information without your authorization, to a health care professional or facility that is named in your Individualized Recovery Plan or Individualized Services Plan, for continuity of your care; to an emergency services provider when clinically required; and in hearings regarding your hospitalization or commitment to the hospital. If you were admitted to a DBHDD facility involuntarily, DBHDD can give notice to the healthcare provider or court that referred you to the hospital, if you transfer to voluntary status or when you are discharged. DBHDD can disclose your protected health information to a health oversight agency, for instance, for audits, investigations, inspections and licensure of a DBHDD facility or program.

c. Legal Requirements: DBHDD may use or disclose your protected health information without your authorization when required to do so by law, to a law enforcement authority or other state agency authorized to receive reports of abuse or neglect. DBHDD may be required by law to use or disclose your protected health information such as by court order in a lawsuit. If we receive a subpoena for your protected health information, we will either notify you of the subpoena, or we will ask the attorney seeking your records to get a protective order for the confidentiality of your protected health information. In the event of your death, DBHDD may use or disclose your protected health information to a coroner or medical examiner in Georgia, an organ or tissue donation organization, and to the legal representative of your estate.

d. HIV or AIDS Confidential Information and Other Reportable Diseases: Georgia law requires DBHDD to report to the Georgia Department of Public Health if you have a disease that is reportable for the protection of public health. This includes HIV infection and other diseases. If you are HIV-positive, DBHDD may also disclose this information in certain circumstances to protect persons at risk of infection by you, including your family and health care providers. DBHDD may also disclose HIV testing or diagnosis information in certain circumstances if we petition the court for an order committing you for involuntary hospitalization or in related legal proceedings. Otherwise, HIV/AIDS information is confidential. See also section 3.b., above.

5. Required Uses and Disclosures: Under the law, DBHDD must make certain disclosures to you, and to the Secretary of the United States Department of Health and Human Services when required to investigate or determine DBHDD's compliance with HIPAA requirements.

6. Practices Not Followed by DBHDD:

a. DBHDD does not sell protected health information of any individual.

b. DBHDD facilities do not maintain directories of admissions.

7. Complaints and Additional Information: You may complain 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.

Please sign a copy of this Notice of Privacy Practices for your provider's and DBHDD's records. I have received a copy of this Notice on the date indicated below.

X _____ _____

Signature of Individual or Legally Authorized Person Date

D·B·H·D·D

NOTICE OF NONDISCRIMINATION:

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (404.657.5964 or 888.785.6954)
ध् य् न द�: य�द आप �ह् द� बोलत् ह� त्ो ो आपक् �लए म् त म� भ ष् सह् यत स व् ए उपलब् ध ह�। (404.657.5964 or 888.785.6954)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (404.657.5964 or 888.785.6954)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (404.657.5964 or 888.785.6954)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로이용하실 수 있습니다. (404.657.5964 or 888.785.6954) 번으로 전화해주십시오.
ВНИМАНИЕ: Если вы говорите на русском языке, то вамдоступны бесплатные услуги перевода. Звоните (404.657.5964 or 888.785.6954).
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (404.657.5964 or 888.785.6954).
ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل (404.657.5964 or 888.785.6954)
�યુ ના: જો તમે �જુ રાતી બોલતા હો, તો ો ન:�લ્ક ભાષા સહાય સેવાઓ તમારા માટ� ઉપલબ્ધ છે. ફોન કરો (404.657.5964 or 888.785.6954).
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (404.657.5964 or 888.785.6954).
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (404.657.5964 or 888.785.6954).
توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما با .باشد می فراهم (404.657.5964 or 888.785.6954)
ማስታወሻ:የሚናገሩትቋንቋአማርኛ ከሆነየትርጉም እርዳታ ድርጅቶች፣በነጻ ሊያግዝዎትተዘጋጀተዋል፡ወደ ሚከተለው ቁጥር ይደውሉ (404.657.5964 or 888.785.6954)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (404.657.5964 or 888.785.6954)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 (404.657.5964 or 888.785.6954). まで、お電話にてご連絡ください。