



NAME _____
PT # _____
For Office Use Only

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize the Medication Access Program (MAP) at The University of Georgia, Augusta, GA, to use or disclose the above named individual's health, financial, and personal data to obtain medications through a medication assistance program(s):

I understand that the information in my record may include information that I do not want disclosed. I do NOT authorize MAP to disclose any information about (Please specify health information): _____

THIS AUTHORIZATION DOES NOT EXTEND TO RECORDS MAINTAINED BY YOUR PHYSICIANS OR MEDICAL INSTITUTIONS.

I understand that enrollment in a medication assistance program or eligibility for free medication is NOT conditioned on my signing this Authorization. However, MAP may condition the provision of healthcare information for the purpose of disclosing to a medication assistance programs upon my agreement to use and disclose this information.

By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorization to the Medication Access Program (MAP) to disclose information about me, and that I may revoke this Authorization at any time by providing a written notice to the Medication Access Program (MAP) to the attention of the Office Operational Manager. The revocation shall be effective except to the extent that MAP has already used or disclosed information in reliance on the Authorization. I understand that my information may be re-disclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. **Please refer to Notice of Health Information Privacy Practices for more detailed information.** Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

Other than healthcare professionals or medication assistance programs, MAP may communicate with the following individuals regarding my condition or course of treatment (for example, print the name of your spouse if we can talk to your spouse about your case): _____

You may communicate confidential information to me by using the following address and/or phone numbers: _____

Individual Signature

As a personal representative, I have authority to act for the individual because I am the individual's _____

Date

Date copy given to patient _____ Processed by _____ Date _____