GEORGIA CRIME VICTIMS COMPENSATION PROGRAM (CVCP)
104 Marietta Street • Atlanta, GA 30303
Office (404) 657-2222 Fax (404) 463-7652 Toll Free (800) 547-0060

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

THIS AUTHORIZATION WILL BE VALID FOR THE DURATION OF THE CLAIM APPLICATION.

Pursuant to O.C.G.A. § 17-15-4-5, The Criminal Justice Coordinating Council (CJCC) is responsible for administering the State of Georgia's Crime Victims Compensation Program (CVCP). In order to determine eligibility for benefits, the CVCP must thoroughly investigate each claim by verifying the date of the victimization, the nature and circumstances surrounding the victimization, and when appropriate a statement indicating the extent of any disability resulting from the injury or serious mental or emotional trauma incurred due to the victimization. ***The CVCP will not be able to render payment to or on behalf of eligible victims/claimants if this consent form is not completed and signed. The CVCP will preserve the confidentiality of all records received.***

SECTION 1. PATIENT INFORMATION			
1a.	Name (First, Middle, Last)	Date of Birth	Social Security Number

SECTION 2. INFORMATION TO BE RELEASED FROM	
2a.	☐ I authorize any hospital, physician, medical facility, insurer or any other person that has knowledge relative to my claim to furnish information to the Georgia Crime Victims Compensation Board for eligibility determination.
2b.	**Please list all known providers:**

SECTION 3: INFORMATION TO BE RELEASED	
3a.	**Please check the applicable box:** ☐ All medical records and/or bills related to the victimization as requested for verification. ☐ Limit the information to the following_____

SECTION 4: PATIENT AUTHORIZATION	
4a.	The purpose of this disclosure is to obtain the information necessary to process the application submitted to the Georgia Crime Victims Compensation Program. I understand that my records may contain information regarding the diagnoses or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. **EXCLUDE** the following information from records released (please initial) ____ Drug/Alcohol abuse/treatment & Diagnosis ____ Sexually transmitted disease ____ HIV/AIDS diagnosis/treatment/testing ____ Mental illness or psychiatric diagnosis/treatment

SECTION 5: RIGHTS OF THE PATIENT	
5a.	I understand that I do not have to sign this authorization form in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To review the process of revoking this authorization, please read the Privacy Notice provided by the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SECTION 6: SIGNATURE	
6a	_____ _____ Print Name (Patient, Guardian*, Authorized Representative*) Date _____ Sign Name (Patient, Guardian*, Authorized Representative*) ** If the authorization was signed by the Patient's personal representative, then proof of Legal Guardianship or Power of Attorney must be provided, to include a description of the patient's personal representative's authority to act on the behalf of the patient in regards to Healthcare.*