AAA Partners In Adoption, Inc.
5665 Hwy. 9, Suite 103-351
Alpharetta, GA 30004

Melissa Clause
Executive Director

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HIPAA RELEASE FORM – Child Protective Services

(APPLICANT: PLEASE COMPLETE THE UPPER SECTION OF THIS FORM AND INCLUDE IT WITH YOUR HOME STUDY APPLICATION)

Name of Individual _____
(Please Print)

Name of Individual_____
(Please Print)

I hereby request and authorize: Department of Family and Children Services–Child Protective Services

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 Child Protective Services

for the purpose of: ADOPTION

I understand that 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 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 or 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USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN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)

