Georgia Department of Human Services
COMPASS Transaction Authorization

I hereby request and authorize: ____
(Name of the Service Site)
To aid me with, and to use any medical, health, or other protected health information that I disclose to its employees, volunteers, or agents for the sole purpose of assisting me with, the following:

O COMPASS Application – Specify program
O Food Stamps O Medicaid O Temporary Assistance for Needy Families (TANF) O Child Care

O COMPASS Renewal of Benefit – Specify program
O Food Stamps O Medicaid O Temporary Assistance for Needy Families (TANF) O Child Care

O COMPASS Report a Change

O COMPASS Benefit Inquiry

I understand I will still be responsible for the acknowledgement and electronic signatures required. I will also submit the transaction on COMPASS.

I understand that the federal Privacy Rule as defined by the Health Insurance Portability and Accountability Act (HIPAA) does not protect the privacy of information if redisclosed, and therefore request that all information if obtained by this Service Site be held strictly confidential and not be further released. I further understand that my eligibility for benefits 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:

O COMPASS Application – the period necessary to complete all transactions on matters related to the application
O COMPASS Renewal/Review of Benefit – the period necessary to complete all transactions on matters related to the renewal/review
O COMPASS Report a Change – the period necessary to complete all transactions on matters related to the change
O COMPASS Benefit Inquiry – one year, unless I specify an earlier expiration date here: _________________

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.

____
(Name of Individual Authorizing the Transaction)

____
(Signature of Individual Authorizing the Transaction)

____
(Individual's Date of Birth)

____
(Client ID Number or Child Care Case Number if Authorizing **Renewal, Report a Change** or **Benefit Inquiry**)

____
(Name of Organization Representative)

____
(Signature of Organization Representative)

____
(Date)

The authorization shall comply with Department policies and must be available to Department contact person or designated representatives, as necessary, during normal business hours for review and comparison against inquiries made on the COMPASS system for a period of three years from the date such authorization is received from the applicant, recipient, or authorized household representative.

Client Waiver

Georgia Department of Human Services

Name of Individual/Consumer/Patient/Applicant

Date of Birth

IF AVAILABLE:

ID Number Used by Requesting Agency | ID Number Used by Releasing Agency

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize: Chatham County Safety Net Planning Council

(Name of Agency Requesting Information) (Name of Agency Requesting Information)

(Address) (Address)

to obtain from: Chatham County DFCS

(Name of Person or Agency Holding the Information)

(Address)

the following type(s) of information from my records (and any specific portion thereof):

assistance with access to Georgia's public health insurance benefits

for the purpose of: benefits eligibility / application and enrollment status

I understand that the federal Privacy Rule ("HIPAA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from 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 or 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: (PLEASE CHECK ONE)

☐ ninety (90) days unless I specify an earlier expiration date here: ____________ (Date)

☐ one (1) year.

☐ 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.

(Date) (Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness) (Title or relationship to Individual) (Signature of Parent or other legally Authorized (Date) Representative, where applicable)

USE THIS SPACE ONLY IF AUTHORIZATION IS WITHDRAWN

(Date this authorization is revoked by Individual) (Signature of Individual or legally authorized Representative)

Form 5459 (Rev. 4-11-03) Previous versions are obsolete and should not be used.