



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:

- COMPASS Application – Specify program  
 Food Stamps  Medicaid  Temporary Assistance for Needy Families (TANF)  Child Care
- COMPASS Renewal of Benefit – Specify program  
 Food Stamps  Medicaid  Temporary Assistance for Needy Families (TANF)  Child Care
- COMPASS Report a Change
- 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:

- COMPASS Application – the period necessary to complete all transactions on matters related to the application
- COMPASS Renewal/Review of Benefit – the period necessary to complete all transactions on matters related to the renewal/review
- COMPASS Report a Change – the period necessary to complete all transactions on matters related to the change
- 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.*

\_\_\_\_\_  
(Print Name of Individual Authorizing 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.