Request for Non-Participation
in GA Notify

Please initial that you have read and understand each the following statements.

_____ Initial — I understand that, by submitting this *Request for Non-Participation in GA Notify,* my test results and medical information will not be accessible to health care providers (including emergency room physicians) through GA Notify

_____ Initial — I hereby authorize GA Notify to block access to my medical health information through GA Notify.

_____ Initial — I understand that I may choose to participate in GA Notify again at any time by contacting GA Notify at ganotify@gha.org .

First Name: _____ Middle Name: _____ Last Name: _____

Previous Last Name: _____ Date of Birth: _____ (Ex: 01/01/1990) Gender: ☐ Female ☐ Male

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone 1: _____ Phone 2: _____

Email Address: _____ Last Four (4) Digits of Social Security Number: _____ (Ex. xxx-xx-1234)

Patient Signature: **X** _____ Date _____
(If under age 18 years, signature of parent or legal guardian)

For your protection, you must verify your identity in order for GA Notify to process the *Non-Participation Request*.

Your identity may be verified one of two ways: have this form signed by a Notary Public or by a Health Care Provider (physician, nurse practitioner, or physicians' assistant) licensed in the State of Georgia.

This form must be returned to GA Notify with original signatures in black or blue ink.

Section to be completed by a Notary Public or Health Care Provider (MD, DO, OD, DDS, DPM, DC, NP, PA, APN)**:**

I witnessed the above-named individual sign this document and the individual is personally known to me or provided me with valid picture identification on this day _____ of _____, 20____.
Day **Month** **Year**

Notary or Provider **Print Name**: _____ Phone Number: _____

Notary or Provider **Signature**: **X** _____ Date Signed: _____

Must be an original signature in black or blue ink.