University of North Georgia

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Student Health Services - Dahlonega
110 South Chestatee Street STE, 100
Dahlonega, GA 30533
Phone: 706-864-1948, Fax: 706-864-1448
Email: immunizations@ung.edu

Student Health Services - Gainesville
3820 Mundy Mill Road
Oakwood, GA 30566
Phone: 696-2676, Fax: 678-696-2686
Email: immunizations@ung.edu

The undersigned hereby authorizes UNG Student Health Services to use or disclose copies of certain medical record information as specified below:

PATIENT NAME_____
ADDRESS_____
BIRTH DATE_____ PHONE NUMBER_____ STUDENT ID #_____

INFORMATION AUTHORIZED FOR USE OR DISCLOSURE:
_____ENTIRE MEDICAL RECORD _____HISTORY & PHYSICAL

_____

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URE OF INFORMATION:
_____
_____

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already obtained, used, or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked, the automatic expiration date will be six (6) months from the date of signature or upon occurrence of the following event: _____.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Rule.
- THE INFORMATION AUTHORIZED FOR USE OR DISCLOSURE MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR SEXUALLY TRANSMITTED DISEASE, WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). _____(Initial)

With this knowledge, I give my authorization to the release of all information in my medical records, including any information concerning my identity, and release University of North Georgia, agents, and employees, from any liability in connection with the release of the information contained therein.

_____ _____
DATE PATIENT SIGNATURE/LEGAL REPRESENTATIVE

_____ _____
DATE WITNESS

COMPLETE THE FOLLOWING IF PATIENT IS DECEASED, A MINOR, OR MENTALLY INCAPACITATED. AUTHORIZATION MAY BE GIVEN BY A LEGALLY AUTHORIZED REPRESENTATIVE, IDENTIFIED BELOW:

_____ _____
REASON PATIENT UNABLE TO SIGN SIGNATURE
_____