University of West Georgia
Health Services

Medical Record Release Form

AUTHORIZATION FOR DISCLOSURE OR USE OF PROTECTED HEALTH INFORMATION

Please complete this form in its entirety. Items not checked or blanks unfilled will be considered as non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature or if it has expired as described below.

I hereby authorize: University of West Georgia
Health Services
1601 Maple Street
Carrollton, Ga 30118
678-839-6452

To disclose the following information from the health records of:

Name: _____
Last First MI

DOB: ____/____/_____ Student ID/SSN: _____

This information is to be disclosed to (Name of provider or entity authorized to disclose your information):

_____

_____

For the purpose of (Choose One): _____Continued Medical Care _____Personal _____ Insurance
The following may be release (please check all that apply):

_____ The entire medical record
_____Medical data related to:
( ) Specific condition(s):_____
( ) Specific dates of service: ____/____/_____ to ____/____/_____
( ) Specific test(s): _____

I understand that this may include information relating to: Acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), and Behavioral health service/psychiatric care, treatment for alcohol and/or drug abuse, and sexually transmitted diseases.

Affirmation of Release:

By signing below I give my permission to the University of West Georgia Health Services to release only the information I have selected on this form to the above named entity. I understand that this release is valid for up to one year from the date of signature and I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during contestability period. Any revocation or refusal to sign this authorization will not affect treatment or payment. I understand that a revocation must be in writing and sent to the University of West Georgia, Health Services, 1601 Maple Street, Carrollton, GA 30118. The revocation must include: patients desire to revoke this authorization; the patient's signature and date of letter. As a patient I also have the right to payment for copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or healthcare clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be disclosed by the recipient and no longer protected by the regulations. I also understand that I have a right to receive a copy of this authorization if I request one.

_____ ____/____/_____
Signature of Patient/Guardian/Legal Representative Date Signed

For office use only:

_____ _____ _____
Faxed or Mailed Date Completed Initials