Student Health and Wellness Center
455 Lee Street Third Floor Ste. 300A
Atlanta, GA 30310
Telephone: (404) 756-1241
Fax: (404) 756-1237

Patient Name: _____

Mailing Address: _____

_____

Date of Birth: _____

Daytime Phone #: _____

Email Address: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I AUTHORIZE:

_____
Name of sending organization /entity

_____
Street Address

_____
City State Zip Code

_____
Phone Fax

TO RELEASE TO:

_____
Name of receiving individual(s), organization /entity

_____
Street Address

_____
City State Zip Code

_____
Phone Fax

Information to be released: (Please specify below)

☐ All Medical Information* **or**

☐ Limited Information to only those item(s) checked below:

☐ Physical Examination records
☐ Clinical/Progress Notes
☐ Immunization records
☐ Laboratory Reports

☐ Other (Specify) _____

☐ **ITEMIZED STATEMENT**

Medical Record Method of Delivery Option: ☐ Postal Mail ☐ Pick-Up ☐ Fax _____

To Request Release of Specifically Protected Information, You Must Initial Below:

☐ Sexually Transmitted Disease (STDS) _____ ☐ Mental Health Records_____ ☐ HIV/AIDS Records

Reason for Disclosure:

☐ Treatment/Continuity of Care ☐ Personal Use ☐ Insurance
☐ Legal ☐ Consultation ☐ Other (Specify) _____

- ☐ I understand that I, or the person authorized to act on my behalf, am entitled to receive a copy of this authorization.
- ☐ The requestor may be provided with a copy of this authorization.
- ☐ I understand that I may inspect my records and that a reasonable fee may be charged for duplication of records. An estimate of charges will be provided upon request before duplication.
- ☐ I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization. I also understand that this authorization **shall expire 45 days from the request date**, unless I specify another date: *Specify date here:* _____. If I decided to revoke this authorization, I will submit my written request to the Supervisor, Medical Records to the address above.
- ☐ I am authorizing any physician, nurse, hospital or other provider having treated or attended me and having possession of any records and/or information with respect thereto, to provide such records to the requesting party identified above.

By signing below, you are hereby authorizing the above named sending entity to release the requested information identified above.

_____
Date

_____
Signature, Patient

_____
Notary Signature

_____
Relationship (if other than patient)

_____
Notary Seal

_____
Commission Expires

*NOTE: If this release pertains to alcohol or drug abuse information, please note that this information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulation (§2 C.F.R. Part 2) prohibits you from asking further disclosure of it without the specific written consent of the patient to who it pertains or as otherwise permitted by such regulations.