UNIVERSITY OF NORTH GEORGIA
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

In order to send your immunization records to a third party health service or educational institution, please fill out the Immunization Release Form and return it to the campus where you originally submitted your immunization info.

Campus	send completed form to:		For questions
Cumming, Gainesville, and Oconee	Student Health Services	Fax: 678-696-2686 Email: immunizations@ung.edu	678-696-2676
Dahlonega	Student Health Services	Fax: 706-864-1448 Email:immunizations@ung.edu	706-864-1948

The undersigned hereby authorizes UNG's Immunization Specialist 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 _____LABORATORY REPORTS

_____PROGRESS NOTES _____IMMUNIZATION RECORD

INFORMATION IS TO BE RELEASED TO:

_____

(NAME) (ADDRESS) (CITY) (STATE) (ZIP CODE)

_____ _____

(PHONE) (FAX)

DATES OF TREATMENT (if applicable):_____

PURPOSE OR NEED FOR THIS DISCLOSURE OF INFORMATION:

_____

_____

I UNDERSTAND:

- ☐ 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 re-disclosure 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 the 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

_____ _____

DATE RELATIONSHIP

REVISED July 2020

If you need this document in another format, please contact Sue White, Sue.White@ung.edu or 706-864-1948