## 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
_____LABORATORY REPORTS
_____IMMUNIZATION RECORD
_____HISTORY & PHYSICAL
_____PROGRESS NOTES
_____ ATTENDED OFFICE VISIT

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 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

____________________________ ____________________________________
DATE RELATIONSHIP

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

REVISED April 2024