University Health Center
The University of Georgia
Athens, GA 30602-1755
(706) 542-8617
(706) 542-4959 fax

Name _____
UGA ID#_____
Gender _____
Date of Birth _____
Phone: _____

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I authorize the University Health Center ("UHC") at The University of Georgia, Athens, GA, to use or disclose the above named individual's health information as described below.

The following information is to be disclosed:

_____ Entire record _____ Immunization Record

_____ Lab results ●List test(s)/date(s) _____

_____ X-ray and imaging reports ●List test(s)/date(s) _____

_____ Last visit ●State dates of service _____

_____ Allergy records ● State dates of service_____

_____ Other ● Specify date(s) of service and/or specific information to be disclosed_____

_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse. **I do NOT authorize UHC to disclose any of the following information**:

AIDS/HIV
Sexually Transmitted Diseases
Alcohol/Drug Abuse
Behavioral/Mental Health

This information may be disclosed to and used by the following individual or organization:

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip code: _____

Purpose of disclosure: At the request of the individual Other _____

I will pick up the copies myself (please allow 24 hours to process and please bring picture ID to pick up). Copies going to another healthcare facility must be mailed to avoid a fee for copies.
Please mail the copies to the address listed above.

A SEPARATE AUTHORIZATION IS REQUESTED TO OBTAIN RECORDS MAINTAINED BY THE UNIVERSITY HEALTH CENTER'S COUNSELING AND PSYCHIATRIC SERVICES.

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is NOT dependent on my signing this Authorization. However, UHC may deem the provision of health care for the purpose of disclosing to a third party protected health information specifically created for that third party, or for participating in research related treatment, upon my agreement to use and disclose this information.

By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorization to the University Health Center to disclose my records, and that I may revoke this Authorization, except if this Authorization was obtained as a condition of obtaining insurance coverage, at any time by providing a written notice to the University Health Center to the attention of the Manager, Registration and Health Information. The revocation shall be effective except to the extent that UHC has already used or disclosed information in reliance on the Authorization. For more detailed information on how to revoke this authorization, please refer to ***Notice of Health Information Privacy Practices***.

I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.

Signature _____ Date _____
(Patient)

Signature _____ Date _____
(Legal Guardian – if patient is 17yrs old or younger/Personal Representative)

Date copy given to patient _____ Processed by _____ Date _____

8/03
Reviewed: 4/04, 7/06, 9/07, 5/08
Revised: 2/06, 6/09, 6/11, 12/11