



UNIVERSITY HEALTH CENTER
The University of Georgia
Athens, GA 30602-1755
(706) 542-1162

Name: _____
SSN: _____
GENDER: _____
DOB: _____

Phone: _____

**MEDICAL AUTHORIZATION
TO OBTAIN HEALTH INFORMATION**

TO: _____

I, _____, hereby authorize the release of the following information to the **University Health Center, The University of Georgia, Athens, GA 30602-1755**. Fax number (706) 542-4959. Please send the records to the attention of _____.

- | | |
|--|---|
| <input type="checkbox"/> Initial evaluation | <input type="checkbox"/> Entire medical records |
| <input type="checkbox"/> Progress notes | <input type="checkbox"/> History and physical |
| <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Psychological testing |
| <input type="checkbox"/> Discharge/treatment summary | |
| <input type="checkbox"/> Diagnostic test results (specify) _____ | |
| <input type="checkbox"/> Other _____ | |

I further authorize you to discuss the above noted information with _____ at the University Health Center.

I understand that I sign this form voluntarily and that I may change my mind at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation. This consent form will expire 90 days following the date signed.

Signature _____ Date _____

*The above consent is given on this patient's behalf because the patient is a minor (), or is unable to sign for the following reasons:

Date _____

* Signature of Closest Relative or Legal Guardian (state relationship)