University Health Center
Student Affairs
UNIVERSITY OF GEORGIA

55 Carlton St.
Athens, GA 30602-1755
(706) 542-8617

Name: _____

UGA ID#:_____

Date of Birth: _____

Vision Clinic | Fax: (706) 227-4763 | Phone: (706) 542-5617

AUTHORIZATION TO OBTAIN, RELEASE OR USE HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT

Check One:

☐ Release Records to

☐ Obtain Records from

Name/Organization: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone:_____ Fax _____

Purpose of disclosure: ☐ At the request of the patient ☐ 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 health care facility must be mailed to avoid a fee for copies

☐ Please mail the copies to the address listed above.

A SEPARATE AUTHORIZATION IS REQUIRED TO OBTAIN RECORDS MAINTAINED BY THE UNIVERSITY HEALTH CENTER'S COUNSELING AND PSYCHIATRIC SERVICES.
By checking the box marked "Entire Record" below, I permit the release or request, as applicable, of my entire medical record, including, if applicable, information concerning drug/alcohol abuse records, venereal disease and other statutorily protected diseases, or AIDS/HIV testing treatment records.

Requested Records		**Released Records**	
☐Entire Record	☐Immunization Record	☐Entire Record	☐Immunization Record
☐Visit Notes	List dates:	☐Visit Notes	List dates:
☐Radiology reports	List dates:	☐Radiology Reports	List dates:
☐Lab Reports	List dates:	☐Lab Reports	List dates:
☐Allergy Records	List dates:	☐Allergy Records	List dates:
☐Other	Specify:	☐Other	Specify:

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is NOT dependent on my signing this Authorization. However, I acknowledge that the University Health Center may condition the provision of health care to me if it is being provided specifically for the purpose of creating protected health information for disclosure to a third party, or is being provided in connection with my participation in research-related treatment, upon my agreement in this Authorization to use and/or disclose such protected health information as specified.

By signing below, I acknowledge that I have read and understand this Authorization, that I have voluntarily given my authorization to the University Health Center to disclose my records to or obtain them from the person/organization listed above, and that I may revoke this Authorization, at any time by providing a written notice to the University Health Center to the attention of the Manager, Registration and Health Information (mgibson@uhs.uga.edu). The revocation shall be effective except to the extent that the University Health Center 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***, available at www.uhs.uga.edu.

I understand that my information may be re-disclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this Authorization. Unless otherwise revoked, this Authorization will expire on the following date, event or condition: _____
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Signature _____ Date _____
(Patient)

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

8/03
Reviewed: 4/04, 7/06, 9/07, 5/08, 4/12 7/13, 5/14, 5/15
Revised: 2/06, 6/09, 6/11, 12/11, 9/16; 2/18