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 _____Referral # _____

☐ Please mail the copies to the address listed above

☐ Please fax the copies to the fax number listed above (limited to healthcare facilities)

☐ Please send records via UGA sendfiles to the e-mail address listed:

_____

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

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 ☐ Alcohol/Drug Abuse

☐ Sexually Transmitted Diseases ☐ Behavioral/Mental Health

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 one year from the date signed or on the following date, event or condition: _____.

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, 9/21
Revised: 2/06, 6/09, 6/11, 12/11, 9/16; 2/18, 11/19