Student Health Services
Valdosta State University
Valdosta, GA 31698

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION PURSUANT TO HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Patient's name _____ **Date of Birth:** _____

Address: _____

City/State/Zip Code: _____

Student ID: _____**Gender:** _____ **Patient's phone #** ( ) _____

Date of Request: _____ **Date Needed:** _____

I authorize:_____
Name of person and/or facility that has information

_____
Street Address, City, State, Zip Code

_____
Fax #

To release health information to:

_____
Specify name/title of person and/or facility to receive health information

_____
Street Address, City, State, Zip Code

_____
Fax #

TYPE OF RECORDS REQUESTED:

- ☐ **Entire Record**
- ☐ **Immunization Record**
- ☐ **Lab Results**(Please list test(s)/date(s) _____
- ☐ **X-Ray & imaging reports** (Please list test(s)/date(s)_____
- ☐ **Last visit** Please state date of service(s) _____
- ☐ **Other** (Please specify date(s) of served or specific information) _____

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 and drug abuse. I do NOT authorize Student Health Services to disclose any of the following information:

☐AIDS/HIV ☐Alcohol/Drug Abuse ☐Sexually Transmitted Disease ☐Behavioral/Mental Health

The purpose of this release is for (check one or more)

- ☐ At the request of the patient/patient representative
- ☐ Other (state reason) _____
- ☐ I will pick up the copies myself (please allow 48 hours to process and please bring a Picture ID to pick up)
- ☐ Please mail the copies to the address listed above.

(Please complete back of form)

THIS AUTHORIZATION DOES NOT EXTEND TO RECORDS MAINTAINED BY THE COUNSELING CENTER.

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is NOT conditioned on my signing this Authorization. However, Student Health Services may condition 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 Student Health Services to disclose my records, and that I may revoke this Authorization, except if the Authorization was obtained as a condition of obtaining insurance coverage, at any time by providing a written notice to Student Health Services to the attention of the Manager of Medical Records. The revocation shall be effective except to the extent that Student Health Services has already used or disclosed information in reliance on the Authorization. I understand that my information may be redisclosed by the authorized person/organization of this agreement. Please refer to Notice of Health Information Privacy for more detail information.

I understand that the University System Office of the Board of Regents of the University System of Georgia and Valdosta State University assumes no responsibility for the use or misuse by others of my health information.

Disclosed under this authorization. I release the Board of Regents of the University System of Georgia and its agents and employees from all legal liability that may arise from this authorization.

EXPIRATION OF AUTHORIZATION
Unless otherwise revoked, this Authorization expires _____ (insert applicable date). If no date is indicated, the Authorization will expire 12 months after the date of signing this form.

_____ _____
Signature Date

The below authorization is given on this patient's behalf because the patient is a minor or is unable to sign for the following reason: _____

_____ _____
Signature (Patient, Parent, Representative) Date

If this form is not submitted in person, it must be notarized.

Notary_____ Date_____

Office Use Only

Date copy given to patient _____ Processed by_____ Date_____

Valdosta State University
Student Health Center
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