

**UNIVERSITY OF WEST GEORGIA HEALTH SERVICES
AUTHORIZATION FOR DISCLOSURE OR USE OF PROTECTED HEALTH INFORMATION**

Please complete this form in its entirety. Items not checked or blanks unfilled will be considered as non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature or if it has expired as described below.

I hereby authorize: University of West Georgia
Health Services
1601 Maple Street
Carrollton, GA 30118
678-839-6452

To disclose the following information from the health records of:

Name _____
Last First MI

Date of Birth: _____ Social Security No. _____

This information is to be disclosed to: (Name of provider or entity authorized to disclose your information):

For the purpose of (Choose One) _____ Continued Medical Care _____ Personal _____ Insurance
The following may be released (please check all that apply):

_____ The entire medical record

_____ Medical data related to:

- () Specific condition(s): _____
() Specific dates of service: _____
() Specific test(s): _____

I understand that this may include information relating to: Acquired immunodeficiency syndrome (AIDS)/human immunodeficiency virus (HIV); Behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; and sexually transmitted diseases.

Affirmation of Release:

By signing below I give my permission to the University of West Georgia, Health Services to release only the information I have selected on this form to the above named entry. I understand that this release is valid for up to one year from the date of signature and I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. Any revocation or refusal to sign this authorization will not effect treatment or payment. I understand that a revocation must be in writing and sent to University of West Georgia, Health Services, 1601 Maple Street, Carrollton, GA 30118. The revocation must include: patients desire to revoke this authorization; the patient's signature and date of letter. As a patient I also have the right to payment for copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or healthcare clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed by the recipient and no longer protected by the regulations. I also understand that I have a right to receive a copy of this authorization if I request one.

Signature of Patient/Guardian/Legal Representative

Date Signed