



Department of Health Services
Carrollton, Georgia 30118

Date: _____

To: _____

Name of Physician, Office, etc...

Phone #: _____

Fax #: _____

I hereby consent to and authorize the release of a copy of _____
_____ records to the following individual or office, for the
purpose of _____.

**University of West Georgia
Health Services
1601 Maple Street
Carrollton, GA 30118-4700
Fax: 678-839-0656**

Student Name (please print)

Birthdate

Student's Signature

Social Security Number

Tel 678-839-6452 • Fax 678-839-0656

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