UNIVERSITY OF WEST GEORGIA

FERPA CONSENT TO RELEASE – TREATMENT INFORMATION

I, _____, _____

Name of Student *(Last, First, Middle)* ***Student ID:*** *(917#)*

consent to the release of my treatment records to the individual(s) listed below for the purpose of keeping them informed about my treatment at the University of West Georgia. I understand that treatment records include, but are not limited to, information about my mental and physical health, medical and counseling services, and medicines.

SECTION A. TREATMENT records to be released

☐ **ALL TREATMENT RECORDS – NO LIMITATIONS [*or CHECK SPECIFIC RECORDS BELOW*]**

☐ **Student Health Services/Medical Records** *(exam reports, physicians orders, medication and treatment records, reports from lab, x-rays and other diagnostic tests, including correspondence and administrative documents.)*

☐ **Student Behavioral/Disability/Mental Health Records** *(mental health history and exams, physician's orders, medication and treatment records, reports and other diagnostic tests, including correspondence and administrative documents.)*

☐ **Other** *(specify and include date(s), for example: Records of Attendance Only)*

_____

SECTION B. Duration of Release

Duration is based on the selected treatment records above to be released.

☐ **Counseling Services - Limited Use**
expires 1 year from date of form or revoked

☐ **Health Services - Extended Use**
expires 6 years from date of form

SECTION C. Access

The University of West Georgia is authorized to release information to the following individual(s) (please print clearly):

PIN Access Code Creation:	
Create a unique PIN (Personal Identification Number) for the designated individual(s). Provide this access code to those individuals and UWG staff will use this PIN code to verify their identity. ***FOUR (4) DIGIT PIN ACCESS CODE:*** _____	_____ ***Name*** _____ ***Mailing Address*** _____ ***City, State, Zip Code*** _____ ***(Area Code) Telephone*** _____ ***Relationship to student***

I understand that (1) I have the right NOT to consent to the release of my TREATMENT records, (2) I have the right to inspect any written records released pursuant to this consent, and (3) I have the right to revoke this consent at any time by submitting a subsequent notification in writing directing the University of West Georgia, Health Services and/or Counseling Center to no longer release information to any or all of the individuals listed above.

By signing, the University of West Georgia is hereby released from all legal responsibility or liability for the release of the above-mentioned information.

_____ _____

Student's Signature (required) ***Date***

IF RETURNING PAPER FORM, RETURN TO APPLICABLE OFFICE(S) AND INCLUDE A COPY OF PHOTO ID:

Health Services
University of West Georgia
1601 Maple Street, Carrollton, GA 30118,
Or FAX (678) 839-0656
EMAIL healthsvc@westga.edu

Counseling Center
University of West Georgia,
1601 Maple Street, Carrollton, GA 30118,
Or FAX (678)-839-6429
EMAIL counseling@westga.edu