UNIVERSITY of West Georgia

Department of Health Services
Carrollton, Georgia 30118

Date:_____

I hereby consent to and authorize the University of West Georgia Health Services to release a copy of my immunization records to the following individual or office:

Name: _____

Address: _____

_____

_____

Fax #: _____

_____ _____

Student Name (please print) Date of Birth

_____ _____

Student Signature Social Security or ID Number

Affirmation of Release:
By signing above 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.

For Office Use Only: _____ _____ _____
Faxed or Mailed Date Completed Initials