University of West Georgia
Health Services

Immunization Release Form

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 Student ID or SSN

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 name entry. I understand that this release is valid for up to one year from the date of the 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 affect treatment or payment. I understand that a 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 of these entities, the information described above may be disclosed 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

Tel 678-839-6452 • Fax 770-830-9713