



University Health Center
Student Affairs
UNIVERSITY OF GEORGIA

55 Carlton St.
Athens, GA 30602-1755
(706) 542-8617

Name: _____

UGA ID#: _____

Date of Birth: _____

Vision Clinic

Fax: (706) 227-4763

Phone: (706) 542-5617

**AUTHORIZATION TO OBTAIN, RELEASE OR USE HEALTH INFORMATION UNDER THE
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
AND THE
FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT**

Check One:

☐ Release Records to _____
Name/Organization: _____
Address: _____

☐ Obtain Records from _____
City: _____ State: _____ Zip code: _____
Phone: _____ Fax: _____

Purpose of disclosure: ☐ At the request of the patient ☐ Other _____

☐ Please mail the copies to the address listed above

☐ Please send records via UGA sendfiles to the e-mail address listed: _____

☐ Please fax the copies to the fax number listed above
(limited to healthcare facilities)

A SEPARATE AUTHORIZATION IS REQUIRED TO OBTAIN RECORDS MAINTAINED BY THE UNIVERSITY HEALTH CENTER'S COUNSELING AND PSYCHIATRIC SERVICES.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse. **I do NOT authorize UHC to disclose any of the following information:**

- ☐ AIDS/HIV ☐ Alcohol/Drug Abuse
☐ Sexually Transmitted Diseases ☐ Behavioral/Mental Health

Requested Records		Released Records	
<input type="checkbox"/> Entire Record	<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Entire Record	<input type="checkbox"/> Immunization Record
<input type="checkbox"/> Visit Notes	List dates: _____	<input type="checkbox"/> Visit Notes	List dates: _____
<input type="checkbox"/> Radiology reports	List dates: _____	<input type="checkbox"/> Radiology Reports	List dates: _____
<input type="checkbox"/> Lab Reports	List dates: _____	<input type="checkbox"/> Lab Reports	List dates: _____
<input type="checkbox"/> Allergy Records	List dates: _____	<input type="checkbox"/> Allergy Records	List dates: _____
<input type="checkbox"/> Other	Specify: _____	<input type="checkbox"/> Other	Specify: _____

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is NOT dependent on my signing this Authorization. However, I acknowledge that the University Health Center may condition the provision of health care to me if it is being provided specifically for the purpose of creating protected health information for disclosure to a third party, or is being provided in connection with my participation in research-related treatment, upon my agreement in this Authorization to use and/or disclose such protected health information as specified.

By signing below, I acknowledge that I have read and understand this Authorization, that I have voluntarily given my authorization to the University Health Center to disclose my records to or obtain them from the person/organization listed above, and that I may revoke this Authorization, at any time by providing a written notice to the University Health Center to the attention of the Manager, Registration and Health Information (mgibson@uhs.uga.edu). The revocation shall be effective except to the extent that the University Health Center has already used or disclosed information in reliance on the Authorization. For more detailed information on how to revoke this authorization, please refer to **Notice of Health Information Privacy Practices**, available at www.uhs.uga.edu.

I understand that my information may be re-disclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this Authorization. Unless otherwise revoked, this Authorization will expire one year from the date signed or on the following date, event or condition: _____.

Signature _____ Date _____
(Patient)

Signature _____ Date _____
(Personal Representative/Legal Guardian – if patient is 17yrs old or younger)

8/03

Reviewed: 4/04, 7/06, 9/07, 5/08, 4/12 7/13, 5/14, 5/15

Revised: 2/06, 6/09, 6/11, 12/11, 9/16; 2/18, 11/19