GEORGIA SOUTHWESTERN
OFFICE OF STUDENT HEALTH
AND COUNSELING SERVICES

Herschel A. Smith Health Services
229.931.2235 OFFICE 229.931.2666 FAX
e-mail: health@gsw.edu

CONSENT FOR AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

By signing this form, I authorize the Herschel A. Smith Health Center of Georgia Southwestern State University to use, release, or disclose the protected health information described below to:

Name and address of person/organization to whom information may be used/disclosed/obtained: (Use separate form for each request)

☒ Obtain the following health information from:

Name: Herschel A. Smith Health Center, Georgia Southwestern State University
Address: 800 Georgia Southwestern State Univ. Drive, Americus, GA 31709 Fax: 229-931-2666

☒ Disclose the following health information to:

Name: _____ Fax: _____
Address, City State, Zip : _____
Email: _____

Transmit this information on or about (information will not be resent absent reauthorization): ___/___/___.
This authorization expires upon fulfillment of request unless special circumstances apply.

Purpose for disclosure: _____

I authorize the following information to be sent to the address above:

- ☐ Copies of all medical records for the period ___/___/___ to ___/___/____.
- ☐ Copies of information described below for period ___/___/___ to ___/___/___.
- ☐ History and Physical Examination ☐ Lab Reports ☐ Reports from Physicians ☐ Immunizations
- ☐ Other (specify) _____

I understand that this information may include any history of acquired immunodeficiency (AIDS); sexually transmitted diseases (STD); human immunodeficiency virus (HIV) infection; behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

Please include on a separate piece of paper any other special instructions or limitations.

I understand that there may be information in these records that I would not wish to be released. I have been provided with a copy of the Herschel A. Smith Health Center and the University System Office Policies and Procedures for HIPAA Compliance and any changes thereto which may be associated with this authorization. I have been provided an opportunity to discuss any concerns I may have about the use or misuse of my health information with the University System Office's privacy officer or other appropriate personnel.

I understand that the University System Office of the Board of Regents of the University System of Georgia and the Herschel A. Smith Health Center assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release the Board of Regents of the University System of Georgia, Herschel A. Smith Health Center and its agents and employees from all legal liability that may arise from this authorization.

Name (please print): _____ Cell Phone # _____
Signed: _____ ID/Social Security #: _____
Date of Birth: _____ Date this Authorization Executed: _____

If the signature above is not that of the person whose medical records are authorized to be released, I am acting for the person whose medical records are being authorized for release:
My relationship to such person is: _____ Signed: _____

The person whose medical records are hereby authorized for release or that person's representative may revoke this authorization by notifying in writing the Health Center. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is otherwise prohibited by the Health Insurance Portability and Accountability Act of 1996. Federal law also requires a statement that there is a potential for the protected health information released under this authorization to be subject to redisclosure by the recipient.

FORM CREATED 29 JAN 03; Revised 05/2004, 04/2005, 11/05, 08/19

Completed by: _____ Date: _____ $1.00 Fee _____