CONSENT FOR AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

This authorization form applies only to the release and disclosure of protected health information (PHI). This authorization is not for treatment or intended for any other purpose.

By signing this form, I authorize my college, my university, my facility, or the University System office and its agents or business associates to use, release, or disclose the protected health information described below to:

Name and address of person/organization to whom information may be sent:

_____

Transmit this information on or about (information will not be resent absent reauthorization): ___/___/___, or, for multiple transmissions, from ___/___/___.

This authorization will expire (check only one):

___ On *(date)*_____, or

___ On occurrence of the following event:_____

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

____ 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 my college, university, facility, or University System 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 my institutional or facility privacy officer or other appropriate personnel.

I understand that my institution or facility, the University System of Georgia, or the Board of Regents of the University System of Georgia 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 and its agents and employees from all legal liability that may arise from this authorization.

Name (please print): _____
Address:_____
Telephone: (____)_____ Fax: (____)_____
Group No.: _____ Group Name:_____
Member ID Number: _____ Social Security Number:_____

Signed:_____
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 privacy officer at the person's university, college or facility. 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