University Health Services
2000 Clayton State Blvd.
Student Center Bldg, Rm 211
Morrow, GA 30260
P: (678) 466 – 4940 F: (678) 466 – 4944

Authorization to Release Medical Records

Patient Name: ______________________________________ Date of Birth: ______/______/_________

Laker ID: ____________________________ Phone: (______)________-____________

Driver License #: __________________________ State of Issue: ________

I, __________________________________ authorize ______________________________ to release the following records included in my medical chart.
(Clinic or Office Name)

Office Phone: (______)________-____________ Office Fax: (______)________-____________

Please check all that apply.

____Physician Notes
____Lab Results
____X-Ray Reports
____Pap Exam
____Immunization Records
____Complete Records
____HIV Testing Information
____Diagnostic Test

I hereby release CSU University Health Services from any liability which may result from this disclosure of confidential information, or which may arise as a result of the use of the information contained in the information released. I understand that I may revoke this authorization by providing written notice by intention. Unless withdrawn, this consent will expire 90 days from the date signed. Date Expired: ______/______/_________

____This information may include Psychiatric and HIV/AIDS information.

____I authorize that this information may be faxed to the requesting Health Care Provider.

Patient's Signature: ____ Date: _____/________/________

Patient's Representative: ____ Date: _____/________/________
(Relationship to Patient)

Authority to sign on behalf of the patient is authorized by ____________________________________.

Witness by: ____
(Picture ID and the patient's signature were used to verify identity.)

**Please note: Records requested for continued care will be mailed directly to the Doctor/Health Care Provider.