Student Health Services
Valdosta State University
Valdosta, GA 31698

Instructions & Information on Records Release form
(Please read first)

Student Health requires the student(patient) to complete and submit an *AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION PURSUANT TO HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)* form. The form must be notarized. If you complete the form and return it to us, we will be happy to respond to your request, including request to release information to your parent(s).

Medical records are saved for ten (10) years after the date of your last visit to Student Health. If you have never been seen by a Student Health provider while enrolled at VSU, your immunization records are kept for two (2) years from the date you enrolled after your departure from this university.

There are times when a student would just like a copy of their immunizations. If you are a current student at VSU, you can obtain a copy of your immunizations by using our online appointment system.

If you have any questions, call Medical Records at 229-219-3203.

*Holds must be satisfied prior to releasing records.

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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION PURSUANT TO HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Patient's name ________________________________ **Date of Birth:** _________________________

Address: ____

City/State/Zip Code: ____

Student ID: ____________________**Gender:** ________ **Patient's phone #** ( ) _____________

Date of Request: ___________________________ **Date Needed:** _____________________________

I authorize:____
Name of person and/or facility that has information

____
Street Address, City, State, Zip Code

____
Fax #

To release health information to:

____
Specify name/title of person and/or facility to receive health information

____
Street Address, City, State, Zip Code

____
Fax #

TYPE OF RECORDS REQUESTED:

- ☐ **Entire Record**
- ☐ **Immunization Record**
- ☐ **Lab Results**(Please list test(s)/date(s)____
- ☐ **X-Ray & imaging reports** (Please list test(s)/date(s)_____________________________________
- ☐ **Last visit** Please state date of service(s) ____
- ☐ **Medication Bill summary from** ____________________**to**______________________________
- ☐ **Other** (Please specify date(s) of service or specific information) ___________________________

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 and drug abuse. I do NOT authorize Student Health Services to disclose any of the following information:

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

The purpose of this release is for (check one or more)

- ☐ At the request of the patient/patient representative
- ☐ Other (state reason)____
- ☐ I will pick up the copies myself (please allow 48 hours to process and please bring a Picture ID to pick up)
- ☐ Please mail the copies to the address listed above.

(Please complete back of form)

THIS AUTHORIZATION DOES NOT EXTEND TO RECORDS MAINTAINED BY THE COUNSELING CENTER.

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is NOT conditioned on my signing this Authorization. However, Student Health Services may condition the provision of health care for the purpose of disclosing to a third party protected health information specifically created for that third party, or for participating in research related treatment upon my agreement to use and disclose this information.

By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my Authorization to Student Health Services to disclose my records, and that I may revoke this Authorization, except if the Authorization was obtained as a condition of obtaining insurance coverage, at any time by providing a written notice to Student Health Services to the attention of the Manager of Medical Records. The revocation shall be effective except to the extent that Student Health Services has already used or disclosed information in reliance on the Authorization. I understand that my information may be redisclosed by the authorized person/organization of this agreement. Please refer to Notice of Health Information Privacy for more detail information.

I understand that the University System Office of the Board of Regents of the University System of Georgia do not assume responsibility for the use or misuse of my health information by others to whom it has been disclosed pursuant to this authorization. I hereby release the University System of Georgia and Valdosta State University, together with their employees, officers, and agents, of and from any liability that may arise from their compliance with this authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires ______________ (insert applicable date). If no date is indicated, the Authorization will expire 12 months after the date of signing this form.

Signature ____________________ Date ____________________

The below authorization is given on this patient's behalf because the patient is a minor or is unable to sign for the following reason: ____________________

Signature (Patient, Parent, Representative) ____________________ Date ____________________

If this form is not submitted in person, it must be notarized.

Notary______________________ Date____________________

Office Use Only

Date copy given to patient ______________ Processed by_________________ Date__________________