Emory University Student Health Services
1525 Clifton Road, Atlanta, Georgia 30322
Phone 404.727.7551 Fax 404.727.5349

Consent for Release of Medical Information from Emory University Student Health Services

Name of Patient: _____ Student ID #: _____ Date of Birth: _____

Emory University, through its Emory University Student Health Services, is authorized to release to:

_____
(Name of Agency or Individual to Whom Release of Information is Authorized)

the following information or documents:

_____

_____

_____

Release by means of: ☐ **Fax:** Fax # (_____) _____-_____ ☐ **Mail:** _____
Street Address

☐ **Release records directly to me (hand carry)**

_____
City State Zip

If checked below, I also request Emory University Student Health Services to specifically release the following records to the above agency or individual and waive any privilege with respect to these specific records:

- ❑ **Records regarding the evaluation and/or treatment of mental health**
- ❑ **Records of infectious or contagious diseases (including HIV/AIDS confidential information)**
- ❑ **Records of drug or alcohol abuse or treatment of same**

I hereby release Emory University Student Health Services, its officers, partners, agents and employees from any and all liabilities, responsibilities, damages and claims that may arise from the release of information authorized above. I understand that once this information has been disclosed to a party other than a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed and is no longer protected by the federal privacy regulations.

I acknowledge that this consent is valid until _____, 20_____. If I fail to specify an expiration date, this consent will be valid for 90 days from the date of my signature.

I understand that I may refuse to sign this consent, and that such refusal will in no way affect my ability to receive treatment, payment for treatment or my eligibility to receive health plan benefits. I understand that I can withdraw this consent for release of information at any time prior to this expiration date, except to the extent that action has been taken in reliance hereon. I further understand that Emory University Student Health Services may refuse to release records where it will be detrimental to my physical or mental health. Should I wish to revoke my consent for the release of information, or if I disagree with a refusal to release records, I should do so in writing as set forth in the Emory University Notice of Privacy Practices (Effective Date: April 14, 2003).

_____ _____
Date Signature of Patient

_____ _____
Legal Representative* Representative's Relationship to Patient*

* Special circumstances, which necessitate other than Patient's signature (for example, patient is less than 18 years of age)

Office Use Only

Completed by: _____ ☐ **Faxed to** ___-____-_____ ☐ **Mailed** ☐ **Released to Patient** **Date:** _____
Staff Members Name