AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

For medical records through March 30, 2014*

Patient Name (at time of service): _____

KSU ID#: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ First Semester at KSU: _____

I authorize release of information to:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

TYPE OF RECORDS REQUESTED:

☐ General medical records related to a specific injury or illness: _____
Type of Illness/Date of Treatment

☐ Entire Record

☐ HIV Results

☐ Pap/Lab Results

☐ Other (Please Describe): _____

To request medical records for office visits **after April 1, 2014 please contact WellStar Medical Group 470-578-6644 or visit one of the KSU Student Health Services Clinics.*

For **immunization records provided as part of the KSU Admissions process, please contact the Immunizations Department located in the Registrar's office: Phone - 470-578-6200; email: immunizations@kennesaw.edu.*

Additional information and forms may be found at **studenthealth.kennesawstateauxiliary.com*

PURPOSE OF THIS REQUEST: ☐ Continuity of Care ☐ Personal Use ☐ Other _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- A new authorization for release of information will be required for each request.
- Release of HIV related information, mental health related care or substance abuse diagnosis and treatment information may require additional authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- There may be a charge for the requested records.

Signature of Patient: _____ Date: _____

Student Health Services

A Division of Auxiliary Services and Programs

3213 Campus Loop Rod, MD 5300.● Kennesaw, GA 30144

Phone: 470-578-3924 ● Fax: 470-578-9332