CONSENT FOR AUTHORIZATION FO

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