



Student Health Service

**MEDICAL COLLEGE OF GEORGIA  
PATIENT AUTHORIZATION FOR USE AND DISCLOSURE  
OF IMMUNIZATION RECORDS**

By signing this authorization, I authorize MCG Student Health Service to use and/or disclose certain protected health information (PHI) about me to

\_\_\_\_\_  
Name of entity to receive this information

\_\_\_\_\_  
PLEASE MAIL :

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
ZIP

\_\_\_\_\_  
PLEASE FAX TO:

This authorization permits MCG Student Health Service to use and/or disclose the following individually identifiable health information.

Immunization records, Tuberculosis skin testing, and/or titer records.

The information will be used or disclosed for the following purpose:

Clearance to participate in clinical education. If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire ninety (90) days from date of signature below.

I do not have to sign this authorization in order to receive treatment from MCG Student Health Service. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to:

**Director, MCG Student Health Service  
Pavilion II, AF1040, Medical College of Georgia  
Augusta, Georgia 30912-9070**

Signed by: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
SHS Chart #

**STUDENT HEALTH FAX: (706)721-7468**