GEORGIA INSTITUTE OF TECHNOLOGY
STAMPS HEALTH SERVICES

PRINT FORM

Patient Authorization for Use and Disclosure of Protected Health Information

Name:_____ Date of Birth:_____Phone # _____GTID#: _____
First Semester at Tech: _____ Email: _____

By signing this form, I authorize Stamps Health Services, including the Psychiatry Clinic, to use, release, or disclose the protected health information which may include confidential psychological and psychiatric information if checked below, unless noted by exclusion or limitation described below. Check all that apply: **RELEASE to:** ☐ **RELEASE from:** ☐

Name: _____ Address: _____ Phone:_____Fax: _____
Name: _____ Address: _____ Phone:_____Fax: _____
Name: _____ Address: _____ Phone:_____Fax: _____
Name: _____ Address: _____ Phone:_____Fax: _____

This protected health information is being used or disclosed for the following purposes:

☐ At the request of the individual ☐ Continuity of Care or Consultation ☐ Evaluation of Academic Concern ☐ Parent Consult
☐ Spouse and/or Domestic Partner Consult ☐ Patient Representative (must attach representative's authority to act for the individual)
☐ Other: _____

The following information is to be disclosed:

☐ Entire record ☐ Radiology reports List dates/tests: _____
☐ Dental record (excludes TechDental) ☐ Lab reports List dates/tests: _____
☐ Blood and/or urine test results ☐ Prescriptions List dates/prescriptions:_____
☐ Immunization record ☐ Billing Information List dates: _____
☐ Letter of summary regarding: _____ ☐ Other: _____

Note any exclusions or limitations here: _____

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 or drug abuse. **I do NOT authorize STAMPS to disclose any of the following information:**

☐ AIDS/HIV ☐ Sexually Transmitted Diseases ☐ Alcohol/Drug Abuse ☐ Psychological/Psychiatric Evaluation or Testing

This authorization expires [specify (1) date or (2) event that relates to the purpose of this use or disclosure].
Date: _____ OR Event: _____

Please allow up to 30 days to process all requests

☐ I will pick up the copies (*please bring your GTID to pick up)* ☐ U.S. Mail the requested documents to the address listed above
☐ Email the requested documents to: _____**Note: This is not secure email. File password protected only**.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. I have been provided with a copy of Stamps Health Services Notice of Privacy Practices. I understand I may discuss any concerns I may have about the use or misuse of my health information with Stamps Health Services Privacy Officer.

I understand that Georgia Institute of Technology and the Board of Regents of the University System of Georgia assume no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Georgia Institute of Technology, its agents and employees, and 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. By signing below, I acknowledge that I have read and understand this document, that I have voluntarily given my authorization to Stamps Health Services to disclose my records. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure 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 Stamps Health Services has acted in reliance upon this notification. My written revocation must be submitted to the Patient Services Manager, Stamps Health Services 740 Ferst Drive, Atlanta, GA 30332-0470.

Signature: _____ Relationship to Patient: _____ Date: _____
Signature of Patient or Patient Representative

_____
Print Patients name or Patient Representative (If applicable)

Date copy given: _____ Date mailed: _____ Processed by: _____

PATIENT/GAURDIAN TO BE PROVIDED WITH A COPY OF SIGNED AUTHORIZATION

Effective Date of Revision 9/22/2017