AUTHORIZATION FOR RELEASE OF IMMUNIZATION RECORD

Student Name:_____ Date of Birth:_____

Address:_____ Phone Number:_____

Student ID #:_____

I hereby consent to and authorize North Georgia College & State University Student Health Services to release a copy of my immunization record to:

_____

(Name) (Phone) (Fax)

_____

(Address) (City) (State) (Zip Code)

By signing below I give permission to NGCSU Student Health Services to release only my immunization records to the requested party. I understand that this release is valid for this date only and I may revoke this authorization at any time, except to the extent that action had been taken in reliance on this authorization or, if applicable, during a contestability period. I understand the revocation must be in writing and sent to North Georgia College & State University, 280 West Main Street, Dahlonega, GA 30597. The revocation must include: students desire to revoke this authorization; the student's signature and date of letter. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or healthcare, clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed by the recipient and no longer protected by this regulation. I also understand that I have a right to receive a copy of this authorization if I request one.

_____ _____

Student Name (please print) Student Signature