Kennesaw State University
Student Health Services
470-578-6644 Fax 470-578-9004

Medical Record Release Form

Patient Demographics:

Name:________________________________ Telephone:____________________________________

DOB:_________________________________

Address:____

I authorize release from: (disclosing party)____

Address:____

Phone:_______________________________ Fax:____

Release To: Wellstar Kennesaw State University Student Health Services
3215 Campus Loop Road, Kennesaw, GA 30144

Please check specific information to be provided to include from (dates)______________ to _____________.
[ ] Full Medical Record
[ ] Immunization Record Only
[ ] Progress Notes
[ ] All diagnostic testing results
[ ] Specific records pertaining to:____

[ ] Other:____

Authorization Statement: I understand that Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal and State Law. I understand that I have the right to revoke this authorization at any time by written communication to the Wellstar location in person and will not apply to any information already used or disclosed. I understand that Wellstar may require me to sign this authorization as a condition to treatment.

Date/Signature:

______________________________________ ______________________________________
Print Patient Name Patient Signature

Date:_________________________________ *This authorization automatically expires in 60 days from date of signature*