

GEORGIA STATE UNIVERSITY

Student Health Clinic & Student Counseling Center
Consent to Release of Health Information

Printed Name of GSU Student

DOB:

Panther ID #

By signing below, I consent to and authorize Georgia State University Student Health Clinic and Student Counseling Center to disclose and or discuss my treatment and health information (which may be protected by HIPAA, FERPA, or state law), to the persons, entities, or agencies designated below.

Please initial and complete all that apply:

Mother [Name: _____ Telephone: _____]

Father [Name: _____ Telephone: _____]

Sibling [Name: _____ Telephone: _____]

Other [Name: _____ Telephone: _____]

GSU Office of the Dean of Students

GSU Housing

Grady Hospital

Please initial your intended duration of consent for the initialed authorizations above:

Single disclosure; or

Continuing disclosure, valid for one year following the date of my signature below.

I understand that I have the right to revoke this consent at any time by sending written notification to the Student Health Clinic and Student Counseling Center at _____. However, revocation shall not apply to the extent that my information has already been disclosed pursuant to this consent.

Signature of GSU Student

DOB:

Panther ID #