



to the extent that Student Health Services has already used or disclosed information in reliance on the Authorization. I understand that my information may be redisclosed by the authorized person/organization of this agreement. Please refer to Notice of Health Information Privacy Practices for more detail information. Unless otherwise revoked, this authorization will expire on the following date, event, or condition December 31, 2010.

I understand that the University System Office of the Board of Regents of the University System of Georgia and Valdosta State University assumes no responsibility for the use or misuse by others of my health information

Disclosed under this authorization. I release 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_

The above authorization is given on this patient's behalf because the patient is a minor or is unable to sign for the following reason: \_\_\_\_\_  
\_\_\_\_\_.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Relative/Guardian/Personal Representative

Date copy given to patient \_\_\_\_\_ Processed by \_\_\_\_\_ Date \_\_\_\_\_