

Valdosta State University

Revocation of Authorization for Disclosure of Health Information

1. I hereby revoke authorization to VALDOSTA STATE UNIVERSITY to disclose information from the medical records of:

Student/Employee name _____ Date of birth _____

Address _____ Telephone _____

Student Social Security number _____

Covering the period(s) of:

From (date) _____ to (date) _____

2. I understand that disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures.

3. Valdosta State University and the Board of Regents of the University System of Georgia its employees and officers are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

Signed: _____
Signature of Student/Employee

Date

Signature of Witness

Date