WELLSTAR Medical Group

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

3215 Campus Loop Road
Kennesaw, GA 30144

1074 Canton Place, Suite 5000
Kennesaw, GA 30144

Medical Record Release Form

Patient Demographics:

Name: _____ Telephone: _____

DOB : _____

Address: _____

I authorize release from: (disclosing party)_____

Address: _____

Phone: _____

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:

_____ or _____
Print Patient name Print Legal Guardian

_____ or _____
Patient Signature Legal Guardian Signature

_____ *This authorization automatically expires in 60 days from date of signature.*
Date