Student Health Services
UNIVERSITY OF SOUTH CAROLINA

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Regarding Patient- COMPLETE IN FULL

Name- Last, First, MI		Birthdate
Local Street Address		
City	State	Zip Code
USC ID	Telephone #	

2. Records Released From:

Name (i.e., Health Facility, Physician)		
Street Address		
City	State	Zip Code
Telephone #	Fax #	

3. Records Released To: ☐ fax, ☐ mail, ☐ verbal, ☐ pick up ☐ other

Name (i.e. Insurance Co., Physician, Self, Parent, translator)		
Street Address		
City	State	Zip Code
Telephone #	Fax #	

4. Reason for Disclosure:

- ☐ Further Medical Care/Referral
- ☐ Changing Physician/Therapist
- ☐ Treatment Planning
- ☐ Medication Evaluation
- ☐ Permission to Speak
- ☐ Hardship Withdrawal
- ☐ Participation in Campus Athletics
- ☐ Personal
- ☐ Insurance
- ☐ Legal/Court
- ☐ Assessment
- ☐ Disability Services
- ☐ Academics
- ☐ Law Enforcement

5. Counseling & Psychiatry (CAPS) Records to be released:

- ☐ Psychotherapy Notes
- ☐ Intake Summary
- ☐ Psychiatric Evaluation
- ☐ Termination/Discharge Summary
- ☐ Psychiatric Notes
- ☐ Medication List/History
- ☐ Billing/Coding
- ☐ Disability/Hardship Letter: _____
- ☐ Ongoing Communication: (DX) _____
- ☐ Other: _____

Date(s) of Treatment/ Visit/DX: _____

6. Medical Records to be released (Excluding CAPS):

- ☐ Visit Notes
- ☐ Physical Exam
- ☐ Allergy Records
- ☐ Immunizations
- ☐ Telephone/Verbal Communication
- ☐ Medication List/History
- ☐ Ongoing Communication
- ☐ X-Ray/EKG
- ☐ Radiographic Images (CD)
- ☐ Laboratory Reports
- ☐ Hospital/Referral Report
- ☐ Billing/Coding
- ☐ Disability/Hardship Letter
- ☐ Entire Record/ Other

Date(s) of Treatment/Letter/Visit/DX: _____

7. Privileged Information to be released:

- ☐ STI/STD
- ☐ HIV/ AIDS
- ☐ Interpersonal Violence Incident
- ☐ Developmental Disability
- ☐ Drug/Alcohol Abuse
- ☐ Other: _____
- ☐ Ongoing Communication: (DX): _____
- ☐ Disability/Hardship/Advocacy Letter: _____

Date(s) of Treatment/ Visit/DX/Incident: _____

8. Patient Rights:

- I understand that signing this form is voluntary. My treatment, payment, or eligibility for services will not be conditioned upon my authorization of this disclosure.
- I may revoke this authorization in writing at any time, except to the extent that action has not already been taken as a result of my signing this form. I may revoke this by sending a Request for Revocation of PHI form to the Medical Records Department of University Health Services.
- I understand that information disclosed under this authorization might be re-disclosed by the recipient and may no longer be protected by privacy laws.
- I understand that a photocopy or facsimile copy of this authorization shall be considered as effective and valid as the original.
- Unless otherwise revoked, this authorization will expire on (date or event) _____.
  - If I fail to specify an expiration date or event, this authorization is valid for **one (1) year** from the date of my signature.

I have read and fully understand the above statements and consent to the disclosure of my health record for the purpose and to the extent stated above. By signing this authorization, I am confirming that it accurately reflects my wishes.

_____ _____

Patient Signature/ Legal Representative (state relationship & authority to do so) Date

For Office Use Only

Date PHI Released (☐ **fax,** ☐ **mail,** ☐ **verbal,** ☐ **pick up** ☐ **other**): _____ Staff /Provider Sign: _____

_____ _____ _____

Description-DX, PHI Released to include dates (i.e., 2 lab reports, 1 office note) Total # Pages Released if applicable Date