University 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 or Last 4 of SSN	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

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 Inquiry
☐ Assessment
☐ Disability Services
☐ Academics

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

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

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 Reports
☐ 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
☐ Ongoing Communication: (DX): _____
☐ Disability/Hardship Letter: _____
☐ Developmental Disability
☐ Drug/Alcohol Abuse
☐ Other: _____

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

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**): _____ Staff /Provider Sign: _____

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