

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:

- | | |
|--|--|
| <input type="checkbox"/> Further Medical Care/Referral | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Changing Physician/Therapist | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Treatment Planning | <input type="checkbox"/> Legal/Court |
| <input type="checkbox"/> Medication Evaluation | <input type="checkbox"/> Assessment |
| <input type="checkbox"/> Permission to Speak | <input type="checkbox"/> Disability Services |
| <input type="checkbox"/> Hardship Withdrawal | <input type="checkbox"/> Academics |
| <input type="checkbox"/> Participation in Campus Athletics | <input type="checkbox"/> Law Enforcement |

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

- | | |
|---|---|
| <input type="checkbox"/> Visit Notes | <input type="checkbox"/> X-Ray/EKG |
| <input type="checkbox"/> Physical Exam | <input type="checkbox"/> Radiographic Images (CD) |
| <input type="checkbox"/> Allergy Records | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Hospital/Referral Report |
| <input type="checkbox"/> Telephone/Verbal Communication | <input type="checkbox"/> Billing/Coding |
| <input type="checkbox"/> Medication List/History | <input type="checkbox"/> Disability/Hardship Letter |
| <input type="checkbox"/> Ongoing Communication | <input type="checkbox"/> Entire Record/ Other |
- Date(s) of Treatment/Letter/Visit/DX: _____

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

- | | |
|--|--|
| <input type="checkbox"/> Psychotherapy Notes | <input type="checkbox"/> Psychiatric Notes |
| <input type="checkbox"/> Intake Summary | <input type="checkbox"/> Medication List/History |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Billing/Coding |
| <input type="checkbox"/> Termination/Discharge Summary | |
| <input type="checkbox"/> Disability/Hardship Letter: _____ | |
| <input type="checkbox"/> Ongoing Communication: (DX) _____ | |
| <input type="checkbox"/> Other: _____ | |
- Date(s) of Treatment/ Visit/DX: _____

7. Privileged Information to be released:

- | | |
|---|---|
| <input type="checkbox"/> STI/STD | <input type="checkbox"/> Developmental Disability |
| <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Drug/Alcohol Abuse |
| <input type="checkbox"/> Interpersonal Violence Incident | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Ongoing Communication: (DX): _____ | |
| <input type="checkbox"/> 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