UNIVERSITY OF SOUTH CAROLINA LANCASTER

Counseling Services

122E Starr Hall
Phone: 803-313-7112
Fax: 803-313-7131

Authorization to Release/Disclose Health Information

Patient's Full Name: ____
Address: ____
Phone Number:______________________________Date of Birth: ________________

I hereby authorize__________________________of The University of South Carolina to use or disclose the following specific health information about myself to ________________
____.

I authorize the following information about myself to be released/disclosed:

- ☐ Assessments (History, Symptoms, Diagnostic)
- ☐ Progress Notes
- ☐ Treatment Plans
- ☐ Other: ______________________

I understand that I may revoke this authorization at any time. If not previously revoked, this authorization will terminate on the following date, event or condition__________________.

If no date or event is listed, this authorization will automatically terminate within 60 days from today.

The University of South Carolina, its employees, faculty, and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Print Full Name: ____

Signature: ______________________________________ Date: ______________