



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:

3. Records Release to: ☐ Fax ☐ Mail ☐ Verbal ☐ Pick up

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

4. Reason for Disclosure: _____

5. Medical Records to be Released (excluding Counseling)

- ☐ 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

6. Counseling & Psychiatry record to be Released

- ☐ Treatment Notes
- ☐ Intake Summary
- ☐ Termination/Discharge Summary
- ☐ Disability/Hardship Letter
- ☐ Ongoing Communication (DX)
- ☐ Other: _____

7. Privileged Information to be Released (excluding counseling)

- ☐ STI/STD
- ☐ HIV/AIDS
- ☐ Interpersonal Violence incident
- ☐ Ongoing communication: (DX): _____
- ☐ Development Disability
- ☐ Drug/Alcohol Abuse
- ☐ Disability/Hardship/Advocacy Letter: _____
- ☐ Other: _____

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 because 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 understand that I may refuse to sign this authorization, and this refusal will not affect my ability to obtain treatment
- I understand that if checked above the PHI released may contain drug and alcohol treatment, communicable diseases and mental health or psychiatric conditions.

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 (relationship & authority to sign) _____ Date _____

For Office Use Only	
Date PHI Released _____	☐ fax, ☐ mail, ☐ verbal, ☐ Pick up ☐ as requested): _____ Staff /Provider Sign: _____