Counseling Services
The University of South Carolina Upstate
800 University Way
Campus Life Center Suite 224
Spartanburg, SC 29303
Phone: 864-503-5195/Fax: 864-503-5358

# *AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION*

## 1. STUDENT INFORMATION- PLEASE COMPLETE IN FULL

| NAME | | | PREFERRED NAME | DATE OF BIRTH |
|---|---|---|---|---|
| LOCAL STREET ADDRESS | | | | |
| CITY | STATE | | ZIP CODE | |
| PHONE NUMBER | | USC Upstate ID | | |

## 2. I AUTHORIZE USC UPSTATE COUNSELING SERVICES TO:

☐ Release Information To ☐ Obtain Information From ☐ Verbally Communicate Information

| NAME | | | |
|---|---|---|---|
| STREET ADDRESS | | | |
| CITY | STATE | | ZIP CODE |
| PHONE NUMBER | | FAX NUMBER | |

## 3. INFORMATION TO BE RELEASED/EXCHANGED

| ☐ Progress Notes | ☐ Complete Record |
|---|---|
| ☐ Termination Summary | ☐ Psychiatric Notes |
| ☐ Treatment/Attendance Dates | ☐ Assessment Report |
| ☐ Other: | |

## 4. NEED FOR DISCLOSURE

| ☐ Administration/Academic Coordination | ☐ Personal |
|---|---|
| ☐ Coordination of Care/Treatment | ☐ Medical Care |
| ☐ Guardian/Familial Communication | ☐ Transferred Schools |
| ☐ Other: | |

## 5. DELIVERY METHOD: ☐ Pick Up (Photo ID Required) ☐ Mail (Via USPS) ☐ Fax

** A valid photo ID must be submitted with the completed request. Please allow **5 business days** for processing. **

## 6. PATIENT RIGHTS

- I understand that signing this form is voluntary.
- I understand that my treatment, payment, or eligibility for services will not be conditioned upon my authorization of this disclosure.
- I understand information disclosed pursuant to this authorization may include HIV/AIDS, treatment for alcohol/drug abuse, and treatment for mental health or psychiatric care.
- I may revoke this authorization at any time by writing to, USC Upstate Counseling Services, except to the extent that action has not already been taken as a result of my signing this form.
- 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 _______________.
  If I fail to specify an expiration date or event, this authorization is valid for **one (1) year** from the date of my signature.

Your signature indicates that you have read and understand this form, and authorizes release of your information as described above.

Student Signature: ____________________________________________________ Date: __________

Legal Guardian Representative|Relationship:________________________________|______ Date: __________
(Required if 17 or younger)

USC Upstate Counseling Services Witness: _________________________________________ Date: __________