UPSTATE
University of South Carolina

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
UNIVERSITY OF SOUTH CAROLINA UPSTATE HEALTH SERVICES

1. Regarding Patient (COMPLETE IN FULL):

Name - Last, First, MI			
Street Address			Telephone #
City	State		Zip Code
USC ID #		Birth date	

2. Records Released From:

Name		
Street Address		
City	State	Zip Code
Phone	Fax	

3. Records Released To:

Name USC Upstate Health Services		
Street Address **800 University Way**		
City Spartanburg	State SC	Zip Code **29303**
Phone **864-503-5191**	Fax **864-503-0754**	

4. REASON FOR DISCLOSURE:

- ☒ Further Medical Care ______________________
- ☐ Legal Inquiry
- ☐ Changing Physician/Therapist
- ☐ Mental Health Treatment/Consult
- ☐ Medication Evaluation
- ☐ Academics
- ☐ Insurance
- ☐ Personal
- ☐ Assessment
- ☐ School Disability
- ☐ Other: ______________________________

5. PHI TO BE RELEASED:

Date(s) of treatment/visit:

- ☐ Medical History, Exam, Physical
- ☐ Prescriptions
- ☐ Allergy Records
- ☐ Immunizations
- ☐ Surgical Reports
- ☐ Telephone/verbal communication
- ☐ Counseling & Consultation Visits
- ☐ Other: ______________________________
- ☐ X-Ray Reports
- ☐ Hospital Reports
- ☐ Laboratory Reports
- ☐ Pap Results
- ☐ Entire Record
- ☐ Itemization/Coding

6. MENTAL HEALTH INFORMATION IF APPLICABLE:

Date(s) of treatment/visit: ______________________

- ☐ Emergencies
- ☐ Progress Status
- ☐ Consultations
- ☐ Intake Summary
- ☐ Assessments/Evaluations ______________________
- ☐ Other ______________________________
- ☐ Attendance/Contact Record
- ☐ Treatment Suggestions
- ☐ Psychiatric Evaluation
- ☐ Termination/Discharge Summary

7. PRIVILEGED INFORMATION TO BE RELEASED:

Date(s) of treatment/visit: ______________________

- ☐ STD
- ☐ HIV/AIDS
- ☐ Alcohol Abuse
- ☐ Developmental Disability
- ☐ Drug Abuse
- ☐ Other: ______________

8. PATIENT RIGHTS:

I have had the opportunity to read this facility's Notice of Privacy Practices (as indicated) and have had all of my questions regarding this Notice answered to my satisfaction. I understand that only health care providers, plans, and clearinghouses must follow the federal privacy standards. If an individual or organization receiving my protected health information (PHI) does not fall into one of these categories, this authorization ceases to be protected by the federal privacy standards therefore, allowing for the possibility of my PHI being redisclosed without further authorization. I understand that I may cancel this authorization but that my withdrawal is only effective to the extent that action has not already been taken, as a result of my signing this form. In order to withdraw this authorization written notification is required.

This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period. Written consent is necessary to revoke this request.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

______________________________ ______________________________

Patient Signature/Legal Representative Date

______________________________ ______________________________

If signor is not the patient, state relationship and authority to do so Witness

For Office Use Only

Date PHI Released (fax or mail) ______________________ ______________________________

Signature

Comments ____