Counseling Services
The University of South Carolina Upstate
800 University Way
John M. Rampey, Jr. Center
Spartanburg, SC 29303
Phone: 864-503-5195/Fax: 864-345-1889

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: _____