

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

<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Complete Record
<input type="checkbox"/> Termination Summary	<input type="checkbox"/> Psychiatric Notes
<input type="checkbox"/> Treatment/Attendance Dates	<input type="checkbox"/> Assessment Report
<input type="checkbox"/> Other:	

4. NEED FOR DISCLOSURE

<input type="checkbox"/> Administration/Academic Coordination	<input type="checkbox"/> Personal
<input type="checkbox"/> Coordination of Care/Treatment	<input type="checkbox"/> Medical Care
<input type="checkbox"/> Guardian/Familial Communication	<input type="checkbox"/> Transferred Schools
<input type="checkbox"/> 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

<ul style="list-style-type: none"> ○ 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 _____. <p style="margin-left: 20px;">If I fail to specify an expiration date or event, this authorization is valid for one (1) year from the date of my signature.</p>
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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: _____