UPSTATE
Health Services

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	**864-503-5099**

4. REASON FOR DISCLOSURE:

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

5. PHI TO BE RELEASED:

Date(s) of treatment/visit:

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

6. MENTAL HEALTH INFORMATION IF APPLICABLE:

Date(s) of treatment/visit: _____

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

7. PRIVILEGED INFORMATION TO BE RELEASED:

Date(s) of treatment/visit: _____

☐ STD
☐ Developmental Disability
☐ HIV/AIDS
☐ Drug Abuse
☐ Alcohol 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 _____