

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
Student Health Services, Coastal Carolina University

1. Patient Information COMPLETE IN FULL:

Name - Last, First, MI	
Local Student Address	Telephone / Cell #
City	State
Zip Code	
ID or SS #	Birth Date

2. Records Released From:

Name - (i.e. Health Facility, Physician...)	
Street Address	
City	State
Zip Code	
Phone #	Fax #

3. Records Released To:

Name (i.e. Insurance Co., Lawyer, Physician, Self...)	
Street Address	
City	State
Zip Code	
Phone #	Fax #

4. REASON FOR DISCLOSURE:

- | | |
|--|--|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Legal Inquiry |
| <input type="checkbox"/> Changing Physician/Therapist | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Mental Health Treatment/Consult | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Medication Evaluation | <input type="checkbox"/> Assessment |
| <input type="checkbox"/> Academics | <input type="checkbox"/> School Disability |
| <input type="checkbox"/> Other: _____ | |

5. Protected Health Information TO BE RELEASED:

- Date(s) of treatment/visit:** _____
- | | |
|---|---|
| <input type="checkbox"/> Medical History, Exam, Physical | <input type="checkbox"/> X-Ray Reports |
| <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Hospital Reports |
| <input type="checkbox"/> Allergy Records | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Pap Results |
| <input type="checkbox"/> Entire Record | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Telephone/verbal communication with my parents/guardian:
Parent/Guardian Name/Address _____ | |

6. PRIVILEGED INFORMATION TO BE RELEASED (Initials Required)

- Date(s) of treatment/visit:** _____
- | | |
|-----------------------|--------------------------------|
| _____ HIV/AIDS | _____ Developmental Disability |
| _____ Alcohol Related | _____ Drug Abuse |
| _____ Mental Health | _____ Other: _____ |

- A detailed message may be left on my cellular phone.
Telephone: _____
- I give Student Health Services permission to speak with my Academic Advisors about matters pertaining to my medical withdrawal.
- If I utilize after hours consult-a-nurse services (Upstate Teleservices), I consent to this service provider releasing protected health information to Student Health Services.

7. PATIENT RIGHTS:

I have had the opportunity to read this facility's Notice of Privacy Practices and Patient Rights and Responsibilities 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, 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 consent will expire at the end of the current academic year.

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 signer is not the patient, state relationship and authority to do so

Witness

Type of Identification Presented