



COASTAL CAROLINA UNIVERSITY
Student Health Services

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I, _____,
(First) (Middle) (Last) (Maiden/Former)

Local Address: _____
(Street) (City) (State/Zip)

Date of Birth: _____ Social Sec. # _____

Telephone # _____ 1st Semester at CCU: YES NO

2. Authorization for CCU Student Health Services to Disclose/Receive Information to/from:

Name: _____

Address: _____

Phone # _____ Fax # _____

3. **Dates of Service Requested:** _____ / _____ / _____ to _____ / _____ / _____
mm dd yy mm dd yy

4. Information to be Disclosed/Received:

Medical Services

- | | | |
|---------------------------------|------------------------|----------------------------|
| _____ Complete Health Record | _____ X-ray Copy | _____ Immunization Records |
| _____ History and Physical Exam | _____ X-ray Reports | _____ Pharmacy Records |
| _____ Consultation Reports | _____ Laboratory Tests | _____ Billing Records |
| _____ Progress Notes | | |

I UNDERSTAND THAT THIS AUTHORIZATION EXPIRES ON _____
(NOT TO EXCEED 1 YEAR) OR SIX MONTHS FROM THE DATE SIGNED, WHICHEVER IS LATER.

5. Purpose of Use or Disclosure _____

(continued on reverse)

6. _____ I authorize CCU Student Health Services to mail my records to the address stated in Section 2.

_____ I authorize CCU Student Health Services to fax my records to the address stated in Section 2.

_____ I will pick up the requested records in person. (Please present CCU ID Card or Valid Driver's License for identification.)

_____ I authorize the aforementioned entity to send the items checked in the information to be Received Section.

I understand that this authorization applies only to the items checked above and is inclusive of the dates indicated. I understand that disclosure to/from anyone other than the name identified in section 2 of this form requires another authorization.

I understand that the information disclosed pursuant to this authorization may include information relating to HIV/AIDs, treatment for drug or alcohol abuse, or mental, behavioral health or psychiatric care.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to SHS. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and federal privacy law or regulations may not protect the information.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Also, this is an **ACKNOWLEDGEMENT OF RECEIPT OF CCU STUDENT HEALTH SERVICES' NOTICE OF PRIVACY PRACTICES.**

Signed: _____ Date: _____
Patient's Signature

Signed: _____ Date: _____
Legal Representative Relationship

Signed: _____ Date: _____
Witness

Type of Identification Presented: _____