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

1. Patient Information COMPLETE IN FULL:

Name - Last, First, MI		
Local Student Address or CCU Box		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, Academics, and Self...)	**Dr. James Solazzo**		
Street Address	**Senior Associate Provost for Student Retention & Completion**		
City Conway	State SC	Zip Code	29528
Phone # **843-349-2821**	Fax #		

NOTICE: Please note that once the requested records are provided to another party by Student Health Services those records may be subject to re-disclosure and not protected by this Authorization and certain federal regulations dealing with the privacy of individually identifiable health information(45 CFR Part 164,Subpart E). This Authorization is intended to provide the patient those protections provided for under the South Carolina Physicians Records Act (S.C. Code Ann.544-115-10 et seq.).

4. REASON FOR DISCLOSURE:

- ☐ Further Medical Care
- ☐ Changing Physician/Therapist
- ☐ Mental Health Treatment/Consult
- ☐ Medication Evaluation
- ☐ Academics
- ☐ Other: ______________________________
- ☐ Legal Inquiry
- ☐ Insurance
- ☐ Prescriptions
- ☐ Assessment
- ☐ School Disability

5. Protected Health Information TO BE RELEASED:

Date(s) of treatment/visit: ______________________________

- ☐ Medical History, Exam, Physical
- ☐ Hospital Reports
- ☐ Allergy Reports
- ☐ Immunizations
- ☐ Mental Health Treatment/Consult
- ☐ Counseling & Consultation Visit
- ☐ Prescriptions
- ☐ Laboratory Reports
- ☐ Pap Results
- ☐ X-ray Reports
- ☐ STD/HIV Testing
- ☐ Other____________

6. Telephone/Verbal communication with my parents/guardian:

Name /Address

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☐ A detailed message may be left on my cellular phone.

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☐ I give Student Health Services permission to speak with my Academic Administrator about matters pertaining to my medical withdrawal.

7. PATIENT RIGHTS:

I have had the opportunity to read this facility's Notice of Privacy Practices 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 signor is not the patient, state relationship and authority to do so Witness

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Type of Identification Presented

For Office Use Only

Date PHI Released (fax or mail)______________________________ ______________________________

Signature

Comments____

Rev. May/22/ 2013