AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Office of Student Health Services, Coastal Carolina University

COMPLETE IN FULL.

1. Patient Information:

Name - Last, First, MI		
Local student address or CCU box		Telephone number
City	State	ZIP code
CCU 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, lawyer, physician, academics, and self...)		
Street address		
City	State	ZIP code
Phone	Fax	

NOTICE: Please note that once the requested records are provided to another party by Student Health Services, those records may be subject to redisclosure and are not protected by this authorization and certain federal regulations dealing with the privacy of individually identifiable heath 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
- ☐ Permission to Speak (as identified in section 3)
- ☐ Legal Inquiry
- ☐ Insurance
- ☐ Personal
- ☐ Assessment
- ☐ School Disability
- ☐ Other: _____

5. Protected Health Information TO BE RELEASED:

Date(s) of treatment/visit:_____

- ☐ Medical History, Exam, Physical
- ☐ Prescriptions
- ☐ Allergy Records
- ☐ Immunizations
- ☐ Mental Health Treatment/Consult
- ☐ Counseling and Consultation Visit
- ☐ Other: _____
- ☐ Entire Record
- ☐ Hospital Reports
- ☐ Laboratory Reports
- ☐ Pap Results
- ☐ X-ray Reports
- ☐ STI Testing

6. ☐ A detailed message may be left on my cellphone.

Number: _____

☐ 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.

Unless otherwise revoked, this authorization will expire on (date or event) _____. If I fail to specify an expiration date or event, this authorization is valid for one (1) year from the date of my signature.

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 the signor is not the patient, state relationship and authority to do so | Witness

_____

Type of identification presented

FOR OFFICE USE ONLY

Date PHI released (fax or email) _____ _____

Signature

Comments _____