Student Health Services

**Coastal Carolina University**

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

# Regarding Patient- COMPLETE IN FULL

|  |  |  |  |
| --- | --- | --- | --- |
| Name- Last, First, MI |  |  | Birthdate |
| Address |  |  |  |
| City | State |  | Zip Code |
| CCU ID |  | Telephone # |  |

1. **Records Released To/From: 3. Records Released To/From:  fax  mail  verbal  pick up**

|  |  |  |
| --- | --- | --- |
| Name (i.e. Health Facility, Physician)Coastal Carolina University Student Health Services |  | Name (i.e. Insurance Co., Physician, Self, Parent, translator) |
| Street Address251 University Boulevard | Street Address |
| City State Zip CodeConway SC 29526 | City State Zip Code |
| Telephone #843-349-6543 | Fax #843-349-6546 | Telephone # | Fax # |

|  |  |  |  |
| --- | --- | --- | --- |
| **4. Reason for Disclosure:** |  | **5. Medical Records to be released:** |  |
| * Further Medical Care/Referral
 | * Personal
 | * Visit Notes
 | * X-Ray Reports
 |
| * Changing Physician/Therapist
 | * Insurance
 | * Physical Exam
 | * Radiographic Images (CD)
 |
| * Treatment Planning
 | * Legal Inquiry
 | * Allergy Records
 | * Laboratory Reports
 |
| * Medication Evaluation
 | * Assessment
 | * Immunizations
 | * Hospital/Referral Report
 |
| * Permission to Speak
 | * Disability Services
 | * Telephone/Verbal Communication
 | * Billing/Coding
 |
| * Other:
 | * Academics
 | * Medication List/History
 | * Letter of Support
 |

* + Ongoing Communication: (DX)  Entire Record/ Other

Date(s) of Treatment/ Visit/DX:

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 are 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.)

* A detailed message may be left on my cellphone. Phone number:
* I give Student Health Services permission to speak with my academic administrator about matters pertaining to my medical withdrawal.

# Patient Rights:

* I understand that signing this form is voluntary. My treatment, payment, or eligibility for services will not be conditioned upon my authorization of this disclosure.
* I may revoke this authorization in writing at any time, except to the extent that action has not already been taken as a result of my signing this form. I may revoke this by sending a Request for Revocation of PHI form to the Medical Records Department of Student Health Services.
* I understand that information disclosed under this authorization might be re-disclosed by the recipient and may no longer be protected by privacy laws.
* I understand that a photocopy or facsimile copy of this authorization shall be considered as effective and valid as the original.
* 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 read and fully understand the above statements and consent to the disclosure of my health record for the purpose and to the extent stated above. By signing this authorization, I am confirming that it accurately reflects my wishes.

Patient Signature/ Legal Representative (state relationship & authority to do so) Date

**For Office Use Only**

Date PHI Released ( fax mail  verbal  pick up): Staff /Provider Sign:

Description-DX, PHI Released to include dates (i.e. 2 lab reports, 1 office note) Total # Pages Released Date