



STUDENT HEALTH SERVICES

Medical University of South Carolina
30 Bee Street – Suite 102, MSC 980
Charleston, SC 29425

Office: (843) 792-3664 Fax: (843) 792-2318

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize MUSC Student Health to: Obtain information FROM Release Information TO

Name of Provider:			
Address:	City:	State:	Zip:
Office Phone: () -		Office Fax: () -	

The purpose of the disclosure is: Medical Follow Up Other _____

Date (s) of Service: _____

- Immunization Record/immune Titers
- Pathology/Pap Reports
- Entire Record
- Lab Results
- Office Notes
- Other _____
- Radiology Reports
- Consultation Reports

I understand this information may include results of tests of chronic infectious diseases including chronic hepatitis B, chronic hepatitis C, TB, HIV/AIDS.

I authorize the exchange of this information via: Mail FAX Other _____

I understand that I have a right to cancel/ revoke this authorization at any time. I understand that if I cancel/ revoke this authorization, I must do so in writing and present my written cancellation/ revocation to the Student Health Services. I understand that the cancellation/ revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled/ revoked, this authorization will expire/ end one year from this date or _____.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and/ or copy the information to be disclosed, as provided in 45 CFR § 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/ organization receiving the information. I understand I will be given a copy of this authorization.

Signature of Student

Date

Printed Name of Student

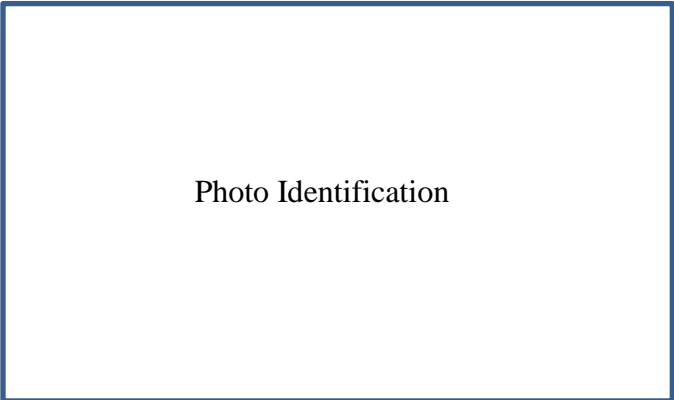


Photo Identification