

Place Patient Label Here

↓Legal Name (Last, First)	Date of Birth (MM/DD/YYYY)	USC ID
↓E-mail Address	Telephone	<input type="checkbox"/> Cell <input type="checkbox"/> Home Phone

I hereby authorize the use and disclosure of protected health information:

↓Release records: <input type="checkbox"/> From or <input type="checkbox"/> To	↓Release records: <input type="checkbox"/> From or <input type="checkbox"/> To
USC Student Health 1031 W. 34th Street, Suite LL-106 Los Angeles, California 90089 Phone: (213) 740-0206 Fax: (213) 740-4961 Email: eshchim@usc.edu	<input type="checkbox"/> Self <input type="checkbox"/> Health Care Provider <input type="checkbox"/> Parent/Legal Guardian <input type="checkbox"/> Other:
	↓Recipient Name (Last, First)
	↓Street Address
	↓City State Zip Code
	↓Telephone Number Fax Number
Delivery Method: <input type="checkbox"/> Pick-Up <input type="checkbox"/> Fax to Number <input type="checkbox"/> Mail to Address <input type="checkbox"/> Opt-Out of Certified Mail <small style="margin-left: 150px;">Initial</small>	

The requested information is to be used for the following purpose: _____

Information requested: Records dated from ___/___/___ to ___/___/___
MM DD YY MM DD YY

- Immunization Records Clinic Note Lab EKG X-ray: Report Image(s)
 All Medical records *(Fees may be applicable, please see page 2)
 Counseling Records Psychiatric Records Relationship and Sexual Violence (RSVP)
 Other health record: _____

In compliance with California Statues which require special permission to release privileged information; **please check the box and initial** if any of these conditions or testing are applicable.

- Initial ___ Mental Health/Psychiatric Initial ___ HIV/AIDS Initial ___ Drug/Alcohol Treatment/Evaluation

This authorization is effective immediately and shall remain in effect for one (1) year for mental health records or until: ___/___/___ (date).
MM DD YY

I may revoke this request at any time. My cancellation will be effective when it has been received in writing by SHC. My revocation must be signed by me and delivered to the address or FAX at the bottom of the page.

Signature of Student _____ Date: _____ ID

If signed by other than patient, please state relationship: _____

Witness: _____ Date: _____

HIM Use Only	Disclose By:	Date:
Comment:		

Additional Information Regarding Disclosure of Patient Health Information

The USC Student Health honors a patient's right to confidentiality of health information as provided under federal and state law. Please read the following guidelines before signing this authorization.

REVOCATION. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your health information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and address to: The USC Student Health, Health Information Management, 1031 W. 34th Street, Suite LL 106, Los Angeles, California 90089-3261

RE-RELEASE. If the person(s) and/or organization(s) authorized by this form to receive your health information are not health care provider or other people who are subjects to federal health privacy laws, the health information they receive may no longer be protected by the federal confidentiality law. However, California law prohibits recipients of your health information from redisclosing your information except with your written authorization or as specifically required or permitted by law.

RIGHT TO INSPECT. You have the right to inspect the medical information whose disclosure you are authorizing, with certain expectations provided under state and federal law. If you would like to inspect your records, contact the Health Information Management Department at (213) 740-0206 for further information.

COPYING FEES. *If you are requesting disclosure/release of health information to other hospitals, clinics, or physicians for further continuum of care, no copy fees will be charged. You must pay for copies for other reasons.*