MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

STUDENT HEALTH SERVICES
30-A Bee Street – PO Box 250980
Charleston, South Carolina 29425
Phone (843) 792-3664
Fax (843) 792-2318

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Full Name (include any former names): _____ **Date of Birth:** _____

SSN: _____ -_____ - _____ **Phone:** _____ **College:** _____**Dates of enrollment:** _____

I authorize MUSC Student Health Services to (check one) ____ disclose/release or to ____ receive information on my behalf.

The type of information to be disclosed is as follows:

For dates of service: _____

❑ Immunization Record / Immune Titers ❑ Laboratory Results ❑ Office Visit / Progress Notes ❑ Consultation Reports

❑ Radiology Reports ❑ Entire Record ❑ Other_____

I understand this information may include reference to psychiatric/psychological care, drug abuse, alcohol abuse, sexual assault, and/or results of tests for all infectious diseases including HIV/AIDS.

I authorize the disclosure of this information via (after I have paid Student Health Services any applicable fees):

❑ in person with proper picture ID ❑ mail ❑ fax ❑ other _____

The information is to be disclosed to: ❑ Self ❑ Individual/Organization:_____

Street Address: _____ City: _____ State: _____ Zip Code _____

Phone Number: _____ Fax: _____

The purpose of the disclosure is: _____

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 Student Health Services. I understand that the cancellation/revocation will not apply to information which 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 90 days from this date.

***I understand that a reasonable cost-based fee (fee schedule available at Student Health Services) for copies of protected health information and postage fees will be charged in accordance to SC law (SC 44-115-80). Fees must be paid to Student Health Services in advance before any records will be released.**

MUSC Student Health Services aims to complete requests within two (2) business days; however if there is a delay, please understand that HIPAA allows thirty to sixty days to respond to an individual's request for a copy of their medical records.

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 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. If I have questions about the disclosure or use of my protected health information, I may contact the MUSC University Privacy Officer.

I understand I will be given a copy of this authorization. I understand that if this information is requested in person I will be asked to provide picture identification (e.g. driver's license). A copy of my identification will be made and attached to this authorization.

_____ _____ _____ _____

Signature **Date** **Witness Signature** **Date**

_____ _____ _____ _____

Legal Guardian/Representative Relationship to Student Witness Signature Date

To contact Student Health Service in writing, the address is: 30-A Bee Street / PO Box 250980 / Attention: Release of Information / Charleston, South Carolina 29425; the phone number is (843) 792-3664.

jfr 3/30/05