

**Authorization Release/Disclosure for Protected Health Information**

**S.C. State University Brooks Health Center**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name:** | Click or tap here to enter text. | **First Name**: | Click or tap here to enter text. |
| **Student ID:** | Click or tap here to enter text. | **Birthdate:** | Click or tap here to enter text. | **Phone/Cell:** | Click or tap here to enter text. |
| **Address:** | Click or tap here to enter text. | **City:** | Click or tap here to enter text. | **State:** | Click or tap here to enter text. | **Zip:** | Click or tap here to enter text. |
| **Purpose for Request /Disclosure:** | **Work** [ ]  **School**  [ ]  **Personal** [ ]  **Lega**l [ ]  **Other**:  |
| **Delivery Method:**  | **Faxed**  [ ]   **Mailed** [ ]  **Email** [ ]  **In Person** [ ]  |

**Please Check One: Obtain** [ ]  **Release** [ ]  **Obtain** [ ]  **Release** [ ]

**S.C. State University** Click or tap here to enter text.

**Brooks Health Center** Click or tap here to enter text.

**POB 7178;300 College St.** Click or tap here to enter text.

**Orangeburg, SC 29117** Click or tap here to enter text.

**Office-803-536-7053 Fax-803-533-3747** Click or tap here to enter text.

**Treatment/visit: From Dates:** Click or tap here to enter text. **Treatment/visit: To Dates:**Click or tap here to enter text.

**Medical Information to be** [ ]  **released or** [ ]  **obtained: Progress/MD/Nurses Notes** [ ]  **Lab Test** [ ]

**Consultation Report** [ ]  **History/Physical** [ ]  **Immunization Record** [ ]  **EKG Report** [ ]  **Other** Click or tap here to enter text.

I have had the opportunity to read this Notice of Privacy Practice and have had all 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 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 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.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or my eligibility for benefits of the health center. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accuratelyreflects my wishes.

**TERM**: I understand that I may revoke this authorization at any time. Unless otherwise revoked, this authorization will expire on the following date:Click or tap here to enter text.

|  |  |  |  |
| --- | --- | --- | --- |
| **Student’s or Legal Representative Signature:** | Click or tap here to enter text. | **Date:** | Click or tap here to enter text. |
| **Relationship to Student:** |  | **ID Presented**  |  |
| **Witness Signature:**  |  | **Date:** |  |

**Confidentiality Note:**

**The information contained in this facsimile is legally privileged and confidential information intended only for the use of the individual or entity named above. If you are not the intended recipient or the employee or agent responsible for delivering this communication to the intended recipient, you are hereby notified that any reading, distribution or copying of this communication is strictly prohibited. If you have received this facsimile in error, please notify us immediately by telephone (803) 536-7053/7055.**