College of Charleston
Student Health Services

Authorization to Disclose Protected Health Information

Patient Name: ____ Date of Birth: ________________________________

Social Security Number: _______________________________________

- ☐ I authorize CofC Student Health Services to disclose/release information to:
- ☐ I authorize CofC Student Health Services to obtain information from:

Name of Organization to release to or obtain health information from: ____

Street Address: _______________________________________ City: ____________________________ State: __________________ Zip Code: __________

Phone #: ____ Fax #: __________________________ Email: _____________________________________

The type of information to be disclosed is as follows: Name of provider requesting info:______________________

- ☐ Entire medical record – may include records from other providers
- ☐ Verbal communication between health care providers
- ☐ Laboratory results _______________________ be specific
- ☐ Immunization records
- ☐ Progress notes _______________________ dates of service
- ☐ Consultation records
- ☐ Radiology results
- ☐ Psycho educational testing

I authorize the exchange of this information via (check all that apply) ☐ mail ☐ fax ☐ e- mail ☐ other

I understand that I have the right to cancel/revoke this authorization. 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. Unless otherwise canceled/revoked this authorization will expire one year from this date.

I understand that a reasonable, cost-based fee for copies of protected health information and postage fees will be charged.

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. 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 Director of Student Health Services at 843-953-5520.

I understand that I may have a copy of this authorization.

I understand that if this information is requested in person I will be asked to provide a photo ID and a copy of this identification will be made and attached to this authorization.

____

Signature of Patient Date

____

Print legal name of Patient

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Mail Completed Form to: College of Charleston
Student Health Services
Charleston, SC 29424

Fax Completed Form to: 843-953-6377 Questions call: 843-953-5520

Fees		
	Page 1 – 10	No charge
	Page 10 – More	$0.50/page