UNIVERSITY OF SOUTH ALABAMA
STUDENT HEALTH CENTER

5870 USA South Drive
MOBILE, AL 36688

Phone (251) 460-7151 Fax (251) 414-8227

AUTHORIZATION TO DISCLOSE HEALTH RECORDS

By initialing the spaces below, I, _____, J00 _____,
DOB: _____, hereby authorize, The University of South Alabama Student Health Center to:

_____release information to:

_____obtain information from:

_____exchange information verbally with:

Name: _____
Street: _____
City: _____ State _____ Zip: _____
Fax:_____
Phone:_____

The information will be used on my behalf for the following purpose(s):

_____

_____

By initialing the spaces below, I specifically authorize the release of the following records, if such records exist:

_____Entire medical record
_____Psychiatric record
_____GYN notes only
_____Laboratory reports
_____X-Ray reports
_____Immunization records
_____HIV test results
_____Sexually transmitted disease information
_____Drug/alcohol diagnosis, treatment, or referral information.
_____This information is limited to the following treatment: _____
_____
_____This authorization is limited to the following time period: _____(be specific)

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request. By providing this authorization, I understand that this protected health information (PHI) may be subject to redisclosure by the recipient of the PHI and no longer protected by the federal Privacy Rules.

_____ _____
Date Signature of Patient or Patient's Legal Representative

_____ _____
Representatives Relationship to Patient (if applicable) Witness

Different forms must be completed for patients with Alabama Medicaid insurance who request a copy of their medical records.