Student Health and Well-Being
UNIVERSITY OF SOUTH CAROLINA

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (ROI) TO INCLUDE COUNSELING & PSYCHOLOGY (CAPS) AND PSYCHIATRY

1. Regarding Patient- COMPLETE IN FULL

Name- Last, First, MI		Birthdate
Local Street Address		
City	State	Zip Code
USC ID	Telephone #	

2. Records Released From: **3. Records Release to:** ☐ Fax ☐ Mail ☐ Verbal ☐ Pick up

Name (i.e., Healthcare Facility)		Name (i.e., Healthcare Facility, Physician, Parent, Translator)	
Street Address		Street Address	
City State Zip Code		City State Zip Code	
Telephone#	Fax#	Telephone#	Fax#

4. **Reason for Disclosure:** _____

5. **Dates of Service you are requesting for sections 6-9**: _____

6. Medical Records to be Released (excluding CAPS & Psychiatry)

☐ Visit Notes
☐ Physical Exam
☐ Allergy Records
☐ Immunizations
☐ Telephone/Verbal Communication
☐ Medication List/History
☐ Ongoing Communication
☐ X-Ray/EKG
☐ Radiographic Images (CD)
☐ Laboratory Reports
☐ Hospital/Referral Report
☐ Billing/Coding
☐ Disability/Hardship Letter

7. CAPS

☐ Treatment Notes
☐ Intake Summary
☐ Termination/Discharge Summary
☐ Disability/Hardship Letter
☐ Ongoing Communication (DX)
☐ Other: _____

8. Psychiatry

☐ Treatment Notes
☐ Intake Summary
☐ Termination/Discharge Summary
☐ Disability/Hardship Letter
☐ Ongoing Communication (DX)
☐ Other: _____

9. Other privileged information to be released

☐ STI/STD
☐ HIV/AIDS
☐ Interpersonal Violence incident
☐ Ongoing communication: (DX): _____
☐ Development Disability
☐ Drug/Alcohol Abuse/Substance Abuse Treatment Records
☐ Disability/Hardship/Advocacy Letter: _____
☐ Other: _____

8. Patient Rights:

I understand that signing this form is voluntary. My treatment, payment, or eligibility for services will not be conditioned upon my authorization of this disclosure.

- **I may revoke this authorization in writing at any time, except to the extent that action has not already been taken because of my signing this form. I may revoke this by sending a Request for Revocation of PHI form to the Medical Records Department of University Health Services.**
- I understand that information disclosed under this authorization might be re-disclosed by the recipient and may no longer be protected by privacy laws.
- I understand that a photocopy or facsimile copy of this authorization shall be considered as effective and valid as the original.
- Unless otherwise revoked, this authorization will expire on (date or event) request complete.
- If I fail to specify an expiration date or event, this authorization is valid for one (1) year from the date of my signature.
- I understand that I may refuse to sign this authorization, and this refusal will not affect my ability to obtain treatment
- I understand that if checked above the PHI released may contain drug and alcohol treatment, communicable diseases and mental health or psychiatric conditions.

I have read and fully understand the above statements and consent to the disclosure of my health record for the purpose and to the extent stated above. By signing this authorization, I am confirming that it accurately reflects my wishes.

Patient Signature/Legal Representative (relationship & authority to sign) _____ Date _____

Revised 7.9.2026

For Office Use Only
Date PHI Released_____ ☐ fax, ☐ mail, ☐ verbal, ☐ Pick up ☐ as requested): _____ Staff /Provider Sign: _____