USC Engemann
Student Health Center

Authorization For Disclosure Of Medical Information

Patient Name		Date of Birth
USC I.D. Number	E-mail Address	Telephone Number

I hereby authorize the use and disclosure of protected health information
from the USC Engemann Student Health Center (ESHC) to:

Recipient: ❑ Self ❑ Doctor ❑ Other:_____

Delivery Method: ❑ Pick-Up ❑ Mail to Address Below ❑ Fax to Number Below

Name		
Street Address	City	State/Zip Code
Telephone Number	FAX Number	

The requested information is to be used for the following purpose: _____

Date(s) of services requested: _____

Information requested:

- ❑ Pertinent Information Includes:
  Clinical Notes, X-ray, Lab, EKG and Immunizations
- ❑ Immunization Records Only
- ❑ Other (please specify):_____

In compliance with California Statutes which require special permission to release privileged information, **please initial and check the box** if any of these conditions are applicable.

❑ _____ Mental Health/Psychiatric ✔ Initial
❑ _____ HIV/AIDS ✔ Initial
❑ _____Drug/Alcohol Treatment/Eval. ✔ Initial

This authorization is effective immediately and shall remain in effect until: _____/_____/_____ (date).
MM DD YY

I may revoke this request at any time. My cancellation will be effective when it has been received in writing by EHSC. My revocation must be in signed by me and delivered to the address or FAX at the bottom of the page.

Signature of Patient: _____ Date: _____

If signed by other than patient, please state relationship: _____

Witness:_____ Date: _____ID ❑

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ESHC • 1031 W. 34th Street, HIM Suite LL106, Los Angeles, California 90089-3261 • (213) 740-0206 • Fax: (213) 740-4961

Additional Information Regarding Disclosure of Patient Medical Information

The Engemann Student Health Center (ESHC) honors a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

Revocation. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your medical information that the person(s) and/or organization(s) listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to: The USC Engemann Student Health Center, Health Information Management, 1031 W. 34th Street, Suite LL106, Los Angeles, California 90089-3261

Re-release. If the person(s) and/or organization(s) authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may no longer be protected by federal confidentiality law. However, California law prohibits recipients of your health information from redisclosing your information except with your written authorization or as specifically required or permitted by law.

Right to Inspect. You have the right to inspect the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact the Health Information Management Department at (213) 740-0206 for further information.

Copying Fees. *If you are requesting disclosure/release of medical information to other hospitals, clinics, or physicians for further medical care, no copy fees will be charged. You must pay for copies you request for other reasons.*

Signatures. Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical record. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact the Health Information Management Department at (213) 740-0206.