USC Engemann Student Health Center
Keck Medicine of USC

Place Patient Label Here

Authorization For Disclosure of Medical Information

↓Legal Name (Last, First)	Date of Birth (MM/DD/YY)	USC ID

E-mail Address	Telephone	☐ Cell	☐ Phone

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

Recipient: ☐ Self ☐ Doctor ☐ Parent/Legal Guardian ☐ Other: _____

Delivery Method: ☐ Pick-Up ☐ Fax to Number Below ☐ Mail to Address Below ___ Opt-Out of Certified Mail
Initial

↓Legal Name (Last, First)			
Street Address	**City**	**State**	**Zip Code**
Telephone Number		**Fax Number**	

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

Information requested:

☐ All Medical records **(Fees may be applicable, please see page 2)*

☐ Clinic Note ☐ X-ray ☐ Lab ☐ EKG: Records dated from ____/____/___ to ____/____/____
MM DD YY MM DD YY

☐ Immunization Records

☐ Other: _____

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

☐____ Mental Health/Psychiatric ☐____ HIV/AIDS ☐____ Drug/Alcohol Treatment/Evaluation
Initial Initial 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:_____

Office Use Only	*Process By:*	*Date:*
Comment:		

1031 W. 34th Street, HIM Suite LL106, Los Angeles, California 90089 • (213) 740-0206 • FAX (213) 740-4961
Email: eshchim@usc.edu

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 revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and address to: The USC Engemann Student Health Center, Health Information Management, 1031 W. 34th Street, Suite LL 106, 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 provider or other people who are subjects to federal health privacy laws, the medical information they receive may no longer be protected by the 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 cer6tain expectations 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 for other reasons.*