College of Charleston
Student Health Services
181 Calhoun Street Charleston, SC 29424
Phone: 843-953-5520 fax: 843-953-6377

Authorization to Disclose/RELEASE Protected Health Information

Patient's Name: _____ Date of Birth: _____

Student Identification Number: _____ Address:_____Phone:_____

❑ Release of Records*
I authorize SHS to ***RELEASE*** records to:

Name of Provider or Facility: _____
Attn: _____
Address: _____

City/State/Zip Code: ___
Phone: FAX:

❑ I am requesting the College of Charleston Student Health Services (SHS) to release the records described below to myself as the Patient or the Personal Representative of the Patient.

❑ Obtaining Records

I authorize SHS to ***OBTAIN*** records from the provider of health care or facility named below:

Name of Provider or Facility: _____
Attn: _____
Address: _____
City/State/Zip Code: _____
Phone: _____ Fax: _____

* **NOTICE**: Please note that once the requested records are provided to another party by the SHS those records may be subject to re-disclosure and not protected by this Authorization and certain Federal regulations dealing with the privacy of individually identifiable health information (45 CFR Part 164, Subpart E). This Authorization is intended to provide the Patient those protections provided for under the South Carolina Physicians' Patient Records Act (S.C. Code Ann. §44-115-10 et seq.).

The type of health information to be disclosed is as follows:

____ Entire medical record [may include records from other providers}: _____ Verbal communication between health care providers
____ Laboratory results _____ Be Specific _____ Immunization records ____ Consultation records
____ Progress Notes _____ Dates of Service _____ Radiology results ____ Psycho educational testing

Student Health Services Requesting Provider: _____
Please provide records by following date:_____

I authorize the exchange of this information via ☐ hand carry ☐ mail ☐ fax ☐ e-mail _____

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.

PURPOSE FOR THIS REQUEST:

❑ At request of Patient or Patient's Personal Representative
❑ Other (describe) _____
*My authority to act as the Personal Representative of the Patient is based on the following:_____

RIGHT OF REVOCATION AND OTHER PATIENT RIGHTS

This Authorization may be revoked by signing where indicated below and by delivering or mailing a signed copy of this Authorization to the Student Health Services at the address below. Neither a subsequent revocation nor a refusal to sign this Authorization will be used as a basis to deny the Patient any treatment, Service, or benefit otherwise available to the Patient as a present or former College of Charleston student. I understand that the cancellation/revocation will not apply to information that has already been released under this Authorization. UNLESS SOONER CANCELED/REVOKED, THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF THE PATIENT/OR REPRESENTATIVE'S SIGNATURE BELOW.

MEDICAL RECORDS WILL BE PROVIDED AT NO CHARGE WHEN THE PATIENT IS REFERRED BY STUDENT HEALTH SERVICES TO ANOTHER PHYSICIAN OR HEALTH CARE PROVIDER FOR CONTINUATION OF TREATMENT FOR A SPECIFIC CONDITION OR CONDITIONS.

I understand I may review and/or copy the information to be disclosed. I acknowledge that I have been advised of my right to receive a signed copy of this Authorization without the need of making a request for such a copy.

Signature of Patient or Legal Representative of Patient* Date

Print legal name of Patient