USF Health
Release of Information

13330 USF Laurel Drive, MDC 33, Tampa, FL 33612
Phone (813) 974-9818   Fax (813) 974-4280

Authorization to Release written and verbal communication of Medical Records, PHI, to Additional providers, family member, Friend and/or Organizations.

Patient Name: ______________________________

DOB: ______________________ Medical Record Number ______________________

Password for verbal communication ______________________ (choose a password that you will share with the individuals you want us to verbally communicate with. We will request this password before releasing any information.)

I authorize release of PHI as defined under "HIPAA" as described on the below authorization form to the following person(s), family member, physician(s) and or organization(s):

By signing this form I understand that I am authorizing the designated medical records custodians or database custodian to use and/or disclose my protected health information (PHI) as defined under 45 CFR 164.501, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as described below to the following person(s) or organization(s)

Name of authorized person(s) or Physician(s: ______________________

Relationship to Patient: ______________________

Street Address: ______________________

City, State and zip code: ______________________

Telephone number: ______________________

Fax number: ______________________

Purpose: ______________________

Date: ______________________

Signature of patient or personal representative ______________________

Printed name of patient or personal representative (circle one) ______________________

Relationship to patient giving representative authority to act for patient ______________________

Patient or personal representative was given a copy of this form ☐ Yes ☐ No

USFPG Staff member completing this process ______________________

Date ______________