USF HEALTH

USF Physicians Group

UNIVERSITY OF SOUTH FLORIDA

Authorization to Records Custodian

RELEASE OF INFORMATION

Patient's Name_____ Date of birth_____

Patient's Social Security No. _____ Medical Record No. _____

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)

Release to: _____

_____
Name

_____
Street Address

_____
City, State, Zip Code

Obtain from: _____

_____
Name

_____
Street Address

_____
City, State, Zip Code

Purpose: _____

I specifically authorize the use and disclosure of the following PHI: (Please provide a detailed description of the particular data and period of time you are requesting) Initial next to A, B, or C

A. _____ALL records in the custody of USF/USF Physicians Group

B. _____ALL records in the custody of _____

C. _____ONLY the following: (Check records being requested)

_____Records of the treating physician _____only

_____Evaluation Initial

_____Follow Up Notes

_____Medication Report

_____Most Recent Discharge Status

_____Other_____

_____Discharge Summary

_____Hospital Admission History and Physical

_____X-rays

_____Lab Results

I understand that I may be charged for the copying of these patient records and payment is expected at the time the copies are received from the University of South Florida/USF Physicians Group.

If requesting information relating to: (1) Acquired immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; (3) mental or behavioral health or psychiatric care, excluding psychotherapy notes or (4) genetic testing, specific authorization on this form or a court order is required since this information is privileged. A separate authorization is required for psychotherapy session notes. Psychotherapy session notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date. 45 CFR 164.501.

I may revoke this authorization form at any time by notifying the above-referenced records custodian at the location listed above, of my intent to revoke this authorization. Returning this form, signed, dated and with the words "authorization revoked" is sufficient notice. However, I understand that such revocation will not have any effect on any information already used or disclosed by the University of South Florida before the University received my written notice of revocation.

This authorization form expires on _____ or when _____ occurs.

I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form.

I understand that I am not required to sign this Authorization form in exchange for the patient receiving treatment from the University of South Florida or _____. I also understand that payment, enrollment in a health plan and/or eligibility for benefits will not be conditioned upon my signing this form.

I understand that I may refuse to sign this form.

There is a potential that the PHI may be re-disclosed by the recipient and no longer protected by federal or state privacy laws.

_____
Signature of patient or personal representative

_____
Date

_____
Printed name of **patient** or **personal representative**

_____
Relationship to patient giving representative authority to act for patient