Medical Health Administration
Employee/Student Health & Wellness
USF Health Quality, Safety, And Risk
College of Medicine

Authorization to Release Medical Information

Record Classification - **(Check one)**: ☐ Resident/Fellow ☐ USF Health Student ☐ Faculty ☐ Staff ☐ Other _____

Employee/Student's Name: _____ Date of Birth: _____

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

Attn: _____

_____
Street Address

_____
City, State, Zip Code

_____ _____
Telephone Number Fax Number

Obtain from: USF Health - Medical Health Administration
Employee/Student Health & Wellness Office

12901 Bruce B. Downs Blvd., MDC 19

Tampa, FL 33612-4799

Telephone: (813) 974 - 3163

Fax: (813) 974 - 3415

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 or B.

_____ A. All records in the custody of USF Health - Medical Health Administration – Employee/Student Health & Wellness Office
_____ B. Only the following: (**Check record(s) being requested)**

☐ Immunizations ☐ X-ray Report

☐ Lab Results ☐ Other _____

I understand that I may be charged for the copying of these records and payment is expected at the time the copies are received from the USF Health - Medical Health Administration – Employee/Student Health & Wellness Office.

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 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.

_____ _____
Printed name of **(check one)**: ☐ employee or ☐ student Date

_____ _____
Signature of **(check one)**: ☐ employee or ☐ student Contact Telephone Number