AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Clemson University, Redfern Health Center
Box 344054, Clemson, SC 29634-4054

Phone: 864-656-2233
Fax: 864-656-0760

______________________________ Dates attended CU: __________

Please PRINT (First name) (Middle name) (Last name)

Other names under which you may have records: ______________________________

CUID/XID: __________ SSN: XXX / XX / ______ D.O.B.: ___/___/___ Phone No.: __________

I hereby authorize Clemson University and/or Redfern Health Center to obtain or disclose my health information as described below:

______release information to: ______obtain information from: ______exchange information verbally with:

Name:______________________________Phone: __________

Street: ______________________________ Fax: __________

City/State/ZIP Code: ______________________________

The information will be used on my behalf for the following purpose(s):

My personal records (fees may apply)
Sharing with other health care providers
Other (please describe) ______________________________

By **marking** the spaces below, I specifically authorize the release of the following medical records, *if such records exist*:

______Entire medical record
______Immunization records
______Laboratory/pathology reports
______Radiology reports/images
______Medication list
______Other: __________

______Pharmacy records
______Medical chart notes
______Account/billing summaries
______Nutritional consultation
______Insurance card

______ HIV/AIDS-related records
______ Counseling and psychological records
______ Drug/alcohol diagnosis, treatment or referral information (*Federal Regulations, 42CFR Part 2, requires a description of how much and what kind of information is to be disclosed).* ______________________________

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______Psychiatric records

______This authorization is limited to the following: ______________________________
(be specific)

______This authorization is limited to the following time period: ______________________________
(be specific)

______This authorization is limited to worker's compensation claim for injuries of date: ______________________________
(be specific)

This consent is effective from________________to________________. If unspecified, this consent will expire one year from date of signature. This consent may be revoked in writing at any time and is effective when received at Redfern Health Center. Actions taken prior to such receipt and in reliance of the initial request are unaffected by subsequent revocation.

I understand that treatment, payment, enrollment in a health plan or eligibility for benefits is NOT dependent on my signing this authorization.

I understand that my information may be re-disclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected by federal privacy laws or regulations.

____

(Signature of patient or person authorized by law) (Date) (Printed Name)

Authority to sign if not patient/client ______________________________

For office use only: Received by: ______________________________ Date: ______________________________

Disposition: ☐ On File ☐ Faxed ☐ Mailed ☐ Released to patient ☐ Verbally released to patient Date: __________ Initials: __________