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
- ☐ Psychiatric 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).* _____

☐ 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: _____

HIM500:5/17,5/13,1/12,9/07,5/03,5/00,5/97