Authorization to Records Custodian
For the Release of Medical Records

13330 USF Laurel Drive, MDC33
Phone: (813) 974-9818 Fax: (813) 974-4280

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT'S LAST FOUR DIGITS OF SOCIAL SECURITY #: _____ MEDICAL RECORD #: _____

REPRESENTATIVE NAME: _____ RELATIONSHIP TO PT.: _____

REPRESENTATIVE ADDRESS: _____ LEGAL AUTHORITY: _____

VERIFICATION OF IDENTIY: _____ VERIFICATION OF AUTHORITY: _____

By signing this form, I understand that I am authorizing the designated medical records custodians or database to use and/or disclose my protected health information (PHI) as defined under 45 CFR 164.051, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPPA) as described below to the following person(s) or organization(s).

RELEASE TO:	**OBTAIN FROM:**
NAME:	NAME:
ADDRESS:	ADDRESS:
PHONE:	PHONE:
CITY/STATE/ZIP CODE:	CITY/STATE/ZIP CODE:

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 and circle specifics:**

A. _____ALL medical records in the custody of USF Health_____
_____Records of the treating physician_____
_____Last office visit Note or Medication List_____
_____Labs or Pathology_____
_____Radiology report or images_____
B. _____Other Information Requested_____
C. _____I further authorize the release of records regarding:
A. _____Mental/Emotional Health B. ____Substance Abuse C. ____HIV/AIDS
D. _____Genetic Information E. ____Records created by Non-USF Health Providers

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 USF Health.
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 emotional 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 164.051
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 (a copy) of this form, signed and dated 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 prior to the University receiving my written notice of revocation. This authorization form expired one year from signature or on _____or the occurrence of _____.
I understand that protected health information released to a third party pursuant to this form may be re-disclosed and may no longer be protected by state and federal law.
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 University of South Florida.
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.

_____ _____
Signature of patient or personal representative Date

_____ _____
Printed name of patient or personal representative Relationship to patient giving representative authority to act for patient.