



EMPLOYEE HEALTH SERVICES

57 Bee Street – MSC 213
Charleston, SC 29425-2130
Telephone (843) 792-2991
Fax (843) 792-1200

**AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION**

Full Name (include any former names) _____ Phone _____

MUSC Employee ID _____ Birth date ____/____/____ Dates of employment _____

I authorize Employee Health Services to disclose/release information on my behalf.

The type of information to be disclosed is as follows:

For dates of service: _____, ___ immunization record, ___ injury reports, ___ other _____

I understand this information may include reference to: psychiatric/psychological care, sexual assault, alcohol abuse, drug abuse, and/or results of tests for all infectious diseases including AIDS/HIV

*** I authorize the disclosure of this information (after I have paid Employee Health Services) via:**

___ in person with proper picture ID or ___ mail

The information is to be disclosed to: ___ Self, ___ Individual/Organization: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone number: (____) _____ Fax number: (____) _____

The purpose of the disclosure is: _____

I understand that I have a right to cancel/revoke this authorization at any time. I understand that if I cancel/revoke this authorization I must do so in writing and present my written cancellation/revocation to MUSC Employee Health Services. I understand that the cancellation/revocation will not apply to information which has already been released in response to this authorization. Unless otherwise canceled/revoked this authorization will expire/end 90 days from this date.

* I understand that a **fee for copies** of protected health information will be charged. The fees to be charged are set by South Carolina law (SC 44-115-80): **sixty-five cents per page** for the first thirty pages and fifty cents per page for all other pages. **Fees must be paid to Employee Health Services in advance before any records will be released.**

Records requests will be processed as quickly as possible. However, please allow **THIRTY DAYS** as per South Carolina law (SC 44-115-80).

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and/or copy the information to be disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/organization receiving the information. If I have questions about the disclosure or use of my protected health information I may contact the MUSC University Privacy Officer.

I understand I have a right to receive a copy of this authorization. I understand that if this information is requested in person I will be asked to provide picture identification (e.g. driver's license). A copy of my identification will be made and attached to this authorization.

Signature _____ **Date** _____

Legal Guardian/Representative Relationship to Employee Witness Signature Date

FOR EHS USE ONLY – Date _____, Initials _____, in person / mailed, # pages _____, pd \$ _____