



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 receive information on my behalf via fax (843) 792-1200.

The type of information to be disclosed is as follows:

For dates of service: _____ Related to (body part/illness): _____

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> immunization records | diagnostic reports: |
| <input type="checkbox"/> physician visit notes | <input type="checkbox"/> CT report |
| <input type="checkbox"/> physical therapy records | <input type="checkbox"/> MRI report |
| <input type="checkbox"/> other _____ | <input type="checkbox"/> X-Ray report |

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

The information is to be disclosed from: 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 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 faxed _____ Initials _____