UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE
UNIVERSITY SPECIALITY CLINIC

AUTHORIZATION FOR USE/ DISCLOSURE OF INFORMATION

Patients Name: _____ Date of Birth: _____

I hereby authorize the disclosure of the following protected health information from the medical record of the above-named.

Entity Receiving Information:

USC Department of Internal Medicine
Division of Pulmonary, Critical Care and Sleep Medicine
One Richland Medical Park Drive, Suite 300
Columbia, SC 29203

Phone: (803) 799-5022 Fax: (803) 799-5890

Entity Providing Information:

Name: _____

_____

Fax #: _____

Phone #: _____

I hereby authorize University Specialty Clinics, Department of Internal Medicine to use the following protected health information:

_____

This protected health information is being disclosed or used for: **Continuation of Care**.

I understand that if the purpose for use or disclosure of my protected health information is for marketing, University Specialty Clinics may receive direct or indirect payment in connection with the marketing.

I understand that I have the right to refuse to sign this authorization and that the University Specialty Clinic, Department of Internal Medicine will not condition my treatment on whether I provide authorization for the requested use or disclosure.

I understand that for the purpose of conducting independent medical exams solely for a third party, University Specialty Clinics will not perform unless I have signed an authorization to release protected health information to the third party.

I understand that information used or disclosed pursuant to this authorization may be subject re-disclosure by the recipient and may no longer be protected by law.

I understand that I have the right to withdraw this authorization by sending a written notice to University Specialty Clinics, Department of Internal Medicine at the above address. I understand that withdrawal is not effective for actions taken prior to the withdrawal.

Authorization expires on: _____

_____ _____

Signature of Patient Date of Signature

OR

_____

Printed name of Patient's Representative

_____

Signature of Patient Representative

_____

Description of representative's authority to sign for Patient