

UNIVERSITY OF SOUTH ALABAMA

COLLEGE OF ALLIED HEALTH PROFESSIONS

DEPARTMENT OF
SPEECH PATHOLOGY AND AUDIOLOGY
SPEECH AND HEARING CENTER

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(Mark whichever is applicable) USE OF PHI _____ DISCLOSURE OF PHI _____ OBTAINING PHI _____

USA SPEECH AND HEARING CENTER AUTHORIZATION FOR USE, DISCLOSURE, OBTAINING PROTECTED HEALTH INFORMATION, WHICH MAY RELATE TO PSYCHOLOGICAL, DRUG OR ALCOHOL CONDITIONS AND/OR DIAGNOSIS, TREATMENT OR CARE FOR HIV+, SEXUALLY TRANSMITTED DISEASE OR COMPLICATIONS RELATED TO SAME.

I hereby authorize **USA Speech and Hearing Center** to use, disclose, or obtain health information from medical record of:
NAME _____

ADDRESS _____

PHONE NO. _____ DATE OF BIRTH _____ SSN _____

- Information that is to be used, disclosed to or obtained: **ALL** (please check) or **SPECIFIC DATES** (please indicate)
Discharge summary _____ Laboratory reports _____ History & Physical _____
X-ray reports _____ Operative/procedure report _____ Pathological report _____
Billing reports _____ Other (specify) _____
- Protected Health Information may be used by, disclosed to or obtained from: **(Include complete address)**

- Purpose of Use and/or Disclosure of PHI:
Attorney/legal _____ Continued treatment _____ Personal use _____
Research _____ Worker's compensation _____ Other (specify) _____

BY PROVIDING THIS AUTHORIZATION, I UNDERSTAND AS FOLLOWS:

- I understand that such medical records may contain information concerning psychological, drug, and/or alcohol conditions, and/or diagnosis, treatment and care of sexually transmitted disease or complications related to sexua