Eric Cohen Student Health Center of USC

Keck Medicine of USC

Last Name, First Name, Middle	Date of Birth (MM/DD/YY)
Program Name	Year of Graduation
USC ID # (For current students only)	Contact Information (Cell # and/or Email)

I hereby authorize the use and disclosure of protected health information
From the Eric Cohen Student Health Center (ECSHC) of USC to:

Recipient: ☐ Self ☐ Doctor ☐ Parent/Legal Guardian ☐ Other:_____

Delivery Method: ☐ Pick-up ☐ Mail ☐ Fax ☐ Email (to Patient's Secure Email Only Listed Above)

Name of Recipient (If other than self)			
Street Address	City	State	Zip Code
Fax # (If applicable)			

The requested information is to be used for the following purpose: _____

Date(s) of service requested: _____

Information requested:

☐ Pertinent Information includes:

Clinical Notes, X-ray, Lab EKG and Immunizations

☐ Immunization Records Only

☐ Other (please specify):_____

In compliance with California Statues which require special permission to release privileged information, please initial and check the box if any of these conditions are applicable.

☐ ____ HIV
Initial

☐ ____ Drug/Alcohol Treatment/Evaluation
Initial

This authorization is effective immediately and shall remain in effect until: ____/____/____ (date).
MM DD YY

I may revoke this request at any time. My cancellation will be effective when it has been received in writing by ECSHC. My revocation must be signed by me and delivered to the address or fax number of ECSHC provided on the next page.

Signature of Patient: _____ Date: _____

If signed by other than patient, please state relationship: _____

Witness: _____ Date: _____