USC Student Health
Keck Medicine of USC

Place Patient Label Here

Authorization For Disclosure of Health Information

↓Legal Name (Last, First)	Date of Birth (MM/DD/YYYY)	USC ID
↓E-mail Address	Telephone ☐ Cell	☐ Home Phone

I hereby authorize the use and disclosure of protected health information:

↓Release records: ☑ From or ☐ To	↓Release records: ☐ From or ☑ To
USC Student Health 1031 W. 34th Street, Suite LL-106 Los Angeles, California 90089 Phone: (213) 740-0206 Fax: (213) 740-4961 Email: eshchim@usc.edu	☐ Self ☐ Health Care Provider ☐ Parent/Legal Guardian ☑ Other: See below. ↓Recipient Name (Last, First) Settlement Panel/Claims Administrators in Tyndall class action. ↓Street Address N/A ↓City State Zip Code N/A ↓Telephone Number Fax Number N/A N/A
Delivery Method: ☐ Pick-Up ☑ Electronic Transfer ☐ Mail to Address	_____ Opt-Out of Certified Mail (Initial)

The requested information is to be used for the following purpose: Consideration of my claim.

Information requested: Records dated from ___/___/___ to ___/___/___ (MM/DD/YY)

☐ Immunization Records ☐ Clinic Note ☐ Lab ☐ EKG X-ray: ☐ Report ☐ Image(s)
☐ All medical records
☐ Counseling Records ☐ Psychiatric Records ☐ Relationship and Sexual Violence (RSVP)
☐ Other health record: _____

In compliance with California statutes which require special permission to release privileged information, **please check the box and initial** if you would like particular records to be sent.

☐ ____ Mental Health/Psychiatric (Initial) ☐ ____ HIV/AIDS (Initial) ☐ ____ Drug/Alcohol Treatment/Evaluation (Initial)

This authorization is effective immediately and shall remain in effect for one (1) year for mental health records or until: ___/___/___ (MM/DD/YY) (date).

I may revoke this request at any time. My cancellation will be effective when it has been received in writing by SHC. My revocation must be signed by me and delivered to the address or FAX at the bottom of the page.

Signature of Student _____ Date: _____ ☐ ID
If signed by other than patient, please state relationship: _____
Witness: _____ Date: _____

You may obtain a copy of this authorization by contacting info@usctyndallsettlement.com.

Additional Information Regarding Disclosure
of Patient Health Information

The USC Student Health honors a patient's right to confidentiality of health information as provided under federal and state law. Please read the following guidelines before signing this authorization.

REVOCATION. You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your health information that the person(s) and/or organization(s) listed on the reverse side of this form have already made in reliance on this authorization. Your revocation must be made in writing and address to: The USC Student Health, Health Information Management, 1031 W. 34th Street, Suite LL 106, Los Angeles, California 90089-3261

RIGHT TO INSPECT. You have the right to inspect the medical information whose disclosure you are authorizing, with certain expectations provided under state and federal law. If you would like to inspect your records, contact the USC Health Information Management Department at (213) 740- 0206 for further information.