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 INFORMAITON, 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 ______________________

1. 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) ____

2. Protected Health Information may be used by, disclosed to or obtained from: (**Include complete address**)
   ____
   ____
   ____

3. 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:

1. 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