Student Health Services
4202 E. Fowler Ave, SHS 100
Tampa, FL 33620
(813) 974-2331
FAX (813) 974-7181

USF STUDENT AFFAIRS
UNIVERSITY OF SOUTH FLORIDA

Counseling Center
4202 E. Fowler Ave, SVC 2124
Tampa, FL 33620
(813) 974-2831
FAX (813) 905-8969

AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF MEDICAL, PSYCHIATRIC/PSYCHOLOGICAL AND MENTAL HEALTH INFORMATION

Name (Please Print): _____

Date of Birth: _____ **Student ID#**_____

By signing this form, I understand that I am receiving services from the University of South Florida (USF) Student Health Services (SHS) and USF Counseling Center (CC).

I am authorizing the disclosure/release/exchange between USF SHS and USF CC of all records and information generated by USF SHS and USF CC and its' providers , including confidential and Protected Health Information (PHI) as defined under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically including but not limited to :

- Medical
- Psychiatric/psychological/mental health (including psychotherapy session notes)
- Alcohol/substance abuse

- Information shall be used in my ongoing treatment.
- Information may be in any format, including but not limited to electronic, photocopy, fax or verbal.
- I understand that signing this authorization is voluntary and my treatment is not conditioned upon signing this authorization.
- I understand that payment for my treatment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my signing this form.
- I understand that information will be exchanged only when deemed relevant to my treatment.
- I understand that I have the right to cancel this authorization at any time. Such revocation will not have any effect on any information already used or disclosed before the written notice of revocation is received.
- This authorization will expire one (1) year from the date set forth below.
- I understand that I may refuse to sign this form.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date