UNIVERSITY OF SOUTH ALABAMA

COLLEGE OF ALLIED HEALTH PROFESSIONS

DEPARTMENT OF
SPEECH PATHOLOGY AND AUDIOLOGY
SPEECH AND HEARING CENTER

TELEPHONE: (251) 445-9378
HAHN 1119, 307 N. UNIVERSITY BLVD.
MOBILE, ALABAMA 36688-0002
FAX: (251) 445-9377

(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