UNIVERSITY OF SOUTH ALABAMA

AUTHORIZATION TO VERIFY SUPPORTING DOCUMENTATION

I, _____, hereby authorize the following party to use, disclose, or verbally verify documentation that pertains to my health and medical information with the University of South Alabama. Verification may include information that published on paper and/or in an electronic format:

Provider: _____

Address: _____

Email: _____

Phone: _____

Fax: _____

STUDENT ACKNOWLEDGMENTS

1. I understand that I can revoke this authorization at any time by submitting written revocation to the provider. However, uses and disclosures permitted while the authorization was in effect cannot be taken back.

2. I understand and acknowledge that the provision of healthcare to me is not conditioned on my execution of this authorization.

3. I understand that information disclosed per this authorization may be subject to redisclosure by the receipt and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA).

☐ Typing my name in this field indicates my signature..

Student Signature: _____

Date: _____

If the student is a minor or unable to sign, please complete the following:

Name of Parent/Guardian: _____

Relationship to Student: _____

Signature of Parent/Guardian: _____

Date: _____