



**USF Health
Release of Information**

13330 USF Laurel Drive, MDC 33, Tampa, FL 33612

DOB: _____ Number _____

_____ (Choose a password that you will

Password for verbal communication
share with the individuals you want us to verbally communicate with. We will request this password before
releasing any information.)

I authorize release of PHI as defined under "HIPAA" as described on the below authorization form to the
following person(s), family member, physician(s) and or organization(s):

By signing this form I understand that I am authorizing the designated medical records custodian to release

Relationship to Patient: _____
Street Address: _____
City, State and zip code: _____
Telephone number: _____
Fax number: _____
Purpose: _____
Date: _____

Signature of patient or personal representative _____

Printed name of patient or personal representative (circle one) _____

Relationship to patient giving representative authority to act for patient _____

Patient or personal representative was given a copy of this form Yes No

USF Health Staff member completing this process _____

Date _____