

# 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 INFORMATION, 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 \_\_\_\_\_

- 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) \_\_\_\_\_
- Protected Health Information may be used by, disclosed to or obtained from: **(Include complete address)**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 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:

- 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