



**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 \_\_\_\_\_