USF Health
Release of Information

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

[redacted]

DOB: [redacted] Number [redacted]

[redacted] (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 custodians and staff [redacted]

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

USFPG Staff member completing this process [redacted]

Date _____