

Information Pertaining to this Authorization

1. The information disclosed to others pursuant to your Authorization may be subject to re-disclosure by the recipient. The USC Lancaster Counseling Services affirms it will take proper and reasonable steps to protect health information in accordance with applicable law, regulations, and rules. However, the USC Lancaster Counseling Services cannot be responsible for the actions of others whom your personal health information is disclosed pursuant to your Authorizations.
2. In order to protect your health information, it is recommended that you limit the information you are authorizing for disclosure to the minimum necessary to meet the intended purpose.
3. This Authorization shall remain in effect for the period you designate, unless revoked earlier in writing by you or your representative. In order to protect your health information, it is recommended you select a realistic but limited expiration date.
 - a. We will continue to act under authorization until the expiration date, unless we receive your written notice of an earlier date. You are responsible for ensuring your written revocation is received by the University of South Carolina Lancaster Counseling Services.
 - b. You have the right to revoke this Authorization at any time, by completing the Revocation Form displayed below or submitted a written revocation to the University of South Carolina Lancaster Counseling Services. You are responsible for ensuring your written revocation is received by the University of South Carolina Lancaster Counseling Services. Your revocation will be effective when received and processed.
4. If your health information is administered under the federal HIPPA law, you may be asked to acknowledge receipt of our Notice of Privacy Practices before we accept your authorization. The Notice of privacy Practices provides important information concerning use and disclosure of your health information.
5. We will attempt to comply with your authorization request in a reasonable time, normally three to five working days. If this does not meet your needs, you should notify your provider. Please verify the contact information on the front of this form is correct in case we have to contact you concerning your request.

Authorization Revocation

I hereby revoke the authorization for use and disclosure of my Protected Health Information appearing on the reverse side of this form. I understand my revocation is not effective for any use or disclosure made in reliance upon my authorization prior to receipt of this revocation by the University of South Carolina Lancaster Counseling Services.

Consumer's or Representative's Name (Please Print) Consumer's ID Number Date

Consumer's or Representative's Signature

If the consumer submits a separate written revocation, complete the following, and attach the revocation document to this form:

Date Revocation Received Name of Staff Member Completing Revocation Action Staff Member Initials