RELEASE OF MEDICAL INFORMATION AUTHORIZATION

SIU SOUTHERN ILLINOIS UNIVERSITY CARBONDALE STUDENT HEALTH SERVICES

Patient Name	Local Phone
Dawg Tag #	Date Of Birth

Release From:

☐ SIUC Student Health Services
☐ Name:_____

Address

City, State, Zip

Phone | Fax

Release To:

☐ SIUC Student Health Services ☐ SIUC Intercollegiate Athletic Trainer
☐ Name:_____

Address

City, State, Zip

Phone | Fax

Purpose

☐ Patient's Request ☐ Other
☐ Attorney/Legal ☐ Continuing Treatment
☐ School Admission Requirement ☐ Insurance

Dates of Records to be Released

From: ____/____/____ To: ____/____/____

How to Release Information

☐ Written ☐ Verbal ☐ Electronic

Sensitive information will not be released unless specifically indicated. Please initial to authorize release:

☐ AIDS/HIV ☐ Behavioral Health ☐ Child Abuse ☐ Developmental Disabilities ☐ Drug/Alcohol Abuse ☐ Genetic Information ☐ Sexual Assault

Requested Method of Delivery

☐ Mail ☐ Pick-up ☐ Fax ☐ Secure Message

Information to be Released:

	Initials
Records of Care:	
☐ Billing Records	
☐ Dental Records	
☐ Immunization Records	
☐ Laboratory Results	
☐ Pap Records	
☐ Radiology Films	
☐ Radiology Report	
☐ Visit Notes	
☐ Other	
Mental Health:	
☐ Professional Testing*	
☐ Psychiatric Evaluation*	
☐ Psychiatric Treatment*	
☐ Psychological Visit Notes*	
☐ Wellness Visit Notes*	

***MUST BE INITIALED BY PATIENT**

Patient Rights:

- This authorization may be revoked by me at any time by written notification to the individual or agency identified above, (see Privacy Notice). However, revocation cannot be retroactive.
- I understand that I have the right to inspect the information to be disclosed and obtain a copy of the authorization for release of information.
- The information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient (if the recipient is not a health care provider or health plan covered by federal privacy regulations) and will no longer be protected by the federal privacy regulations.
- I understand that I am not required to sign this authorization form and that SHS will not condition the provision of treatment or payment to me on the signing of this authorization. SHS may condition the provision of health care to me that is solely for the purpose of creating protected health information for disclosure to a third party on the signing of this authorization.
- I absolve, discharge, release, and hold harmless the individual or agency identified above and the Board of Trustees for Southern Illinois University together with its officers and employees for any legal liability, claims, or damages which may arise from disclosure of this information.
- Consent is valid from date signed to _____/_____/_____, unless revoked earlier. Authorization is valid for 90 days unless otherwise indicated.

Signature of Patient or Consenting Individual _____ Date _____

If signature is not of Patient, indicate relationship and authority _____ Date _____

Signature of Witness _____ Title _____ Date _____

**NOTICE TO RECEIVING AGENCY/FACILITY/PERSON: You may not redisclose any records disclosed to you pursuant to the Illinois Mental Health and Developmental Disabilities Confidentiality Act (720 ILCS 110/ et. seq.) or the federal Alcohol Drug Treatment regulations, (42 CFR 2 et seq.) unless the person who consented to this disclosure specifically consents to such redisclosure.

For the release of Counseling & Psychological Services records please contact the Counseling & Psychological Services at 618-453-5371

State of Illinois Comptroller's Office sets annual adjustment of copying fees as required under 735-ILCS 5/8-2006

Contact Information:
Student Health Services
374 East Grand Avenue
Mail Code 6740
Carbondale, IL 62901

Phone: 618/453-3311
Fax: 618/453-4088
Website: shc.siu.edu
Email: medicalrecords@siu.edu
Immunization Records email: immunizations@siu.edu

Processed by:

Date: _____/_____/_____ Fees: $ _____

Clear Form Print Form