

# RELEASE OF INFORMATION FORM

## 1. Patient Information:

Patient Name: \_\_\_\_\_  
Dawg Tag#: \_\_\_\_\_

Local Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

## 2. I authorize **SIUC Student Health Services** to ( Release Obtain Exchange) Protected Health Information

From  To Agency / Facility / Person: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ (For Health Care Facility Fax Use Only)

*Intra-Organizational Use only:*    \_\_\_ From \_\_\_ To Athletic Department    \_\_\_ From \_\_\_ To Clinical Center  
\_\_\_ From \_\_\_ To CAPS    \_\_\_ From \_\_\_ To Disability Support Services    \_\_\_ From \_\_\_ To SHS Psychiatric Department  
\_\_\_ From \_\_\_ To SHS Clinic    \_\_\_ From \_\_\_ To Transitional Services    \_\_\_ From \_\_\_ To Student Rights/Responsibilities

## 3. Records to Be Released (Initials required):

\_\_\_ Psychiatric Treatment\*    \_\_\_ Psychiatric Eval.\*    \_\_\_ Psychological Treatment\*    \_\_\_ Other: \_\_\_\_\_

\_\_\_ Billing Records    \_\_\_ Laboratory Results    \_\_\_ Immunization Records

\_\_\_ Radiology Studies    \_\_\_ Radiology Report    \_\_\_ Medical Visit Notes

\*Psychiatric and Psychological records released WILL include any applicable sensitive information regardless of any exclusions checked below

## 4. It is in my full understanding that the records and communication to be disclosed **WILL** include the following **sensitive information** categories unless specifically excluded by me: **INITIAL BELOW FOR EXCLUSION ONLY.**

\_\_\_ AIDS/HIV    \_\_\_ Child Abuse    \_\_\_ Drug/Alcohol Abuse    \_\_\_ Genetic Information

\_\_\_ Developmental Disabilities    \_\_\_ Sexual Assault    \_\_\_ Mental Health    \_\_\_ Pregnancy

## 5. Purpose of Release: Patients Request to Patient    Continuing Treatment    School Admission Requirement

Attorney/Legal     Insurance     Other: \_\_\_\_\_

## 6. Date of Service Range for Records to Release: From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_    All Dates (Mental Health Only)

## 7. Information Format: Electronic    Verbal    Paper

Method of Delivery:  Mail     Fax     Pick Up     Secure Portal    DropBox E-mail: \_\_\_\_\_

## 8. This authorization, unless revoked earlier, is valid through: (Must supply date to process): Month \_\_\_\_\_ Day: \_\_\_ Year: \_\_\_

## 9. Patient Rights:

- I have the right to inspect and copy the information to be disclosed and obtain a copy of this authorization.
- 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.
- Any disclosure of information has the potential for an unauthorized re-disclosure by the recipient and as such would no longer be protected by the law \*\*
- 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 services to me 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.

## 10. Signature of Patient/Consenting Individual: \_\_\_\_\_ Date Signed: \_\_\_\_\_

If Signature is not of Patient, print your name legibly and indicate relationship to patient & authority \_\_\_\_\_

## 11. Witness (Print Name) \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

By signing above Witness attests that the Patient/Consenting Individual signing above personally appeared before Witness and proved to Witness through satisfactory evidence to be the person whose name and signature is subscribed as Patient/-Consenting Individual herein or was personally know to Witness to be such person.

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

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

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Processed by: _____	Date: _____
Approved by: _____	Date: _____