RELEASE OF INFORMATION FORM

1. Patient Information:
Patient Name: _____ Local Phone: _____
Dawg Tag#: _____ 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	*CAPS*	___From	___To	*Athletic Department*	___From	___To	*Clinical Center*
___From	___To	*SHS Clinic*	___From	___To	*Disability Support Services*	___From	___To	*SHS Psychiatric Department*
			___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 ☐ Verbal ☐ Pick Up ☐ 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/☐***Verbal Consent: _____Date Signed _____
If Signature is not of Patient, print your name legibly and indicate relationship to patient & authority_____
_____

11. Signature of Witness _____ Title _____ 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/ 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 re-disclosure.*Verbal consent Requires two signatures and is **NOT valid for Mental Health Records**.

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: