

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* PT Visit Notes
 Billing Records Dental Records Laboratory Results Immunization Records
 Radiology Studies Radiology Report Medical Visit Notes Other: _____

*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 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 Print Method of Delivery: Print Verbal Pick Up Electronic 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 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 _____ If Signature is not of Patient, indicate relationship & authority _____ Date _____ Signature of Witness _____ Title _____ Date _____

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

Contact Information:
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Website: shc.siu.edu
Email: medicalrecords@siu.edu

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