

# Release of Medical Information Authorization

Student Health Center

Mailcode 6740 · 374 East Grand Avenue · Carbondale, IL 62901

Ph: 618/453-3311 Fax: 618/453-4088

Patient Name	Local Phone
ID #	Date Of Birth

### Release From

<input type="checkbox"/> SIUC Student Health Center <input type="checkbox"/> Name: _____	
Address	
City, State, Zip	Phone/fax

### Release To

<input type="checkbox"/> SIUC Intercollegiate Athletic Trainer <input type="checkbox"/> SIUC Student Health Center <input type="checkbox"/> Name: _____	
Address	
City, State, Zip	Phone/fax

Purpose	Dates of Records to be Released	How to Release Information
<input type="checkbox"/> Patient's Request <input type="checkbox"/> Further Treatment <input type="checkbox"/> Legal <input type="checkbox"/> Other	From: ___/___/___ To: ___/___/___	<input type="checkbox"/> Written <input type="checkbox"/> Verbal <input type="checkbox"/> Both Written and Verbal

### Information to be Released      Initials

<input type="checkbox"/> Allergy records	
<input type="checkbox"/> Insurance	
<input type="checkbox"/> X-ray report	
<input type="checkbox"/> X-ray films	
<input type="checkbox"/> Physical	
<input type="checkbox"/> Laboratory results	
<input type="checkbox"/> Diagnosis	
<input type="checkbox"/> Progress notes	
<input type="checkbox"/> Dental Records	
<input type="checkbox"/> Immunization records	
<input type="checkbox"/> Psychiatric treatment*	
<input type="checkbox"/> Professional testing*	
<input type="checkbox"/> Psychiatric evaluation*	
<input type="checkbox"/> AIDS/HIV related records*	
<input type="checkbox"/> Counseling*	
<input type="checkbox"/> Alcohol/Drug Records*	
<input type="checkbox"/> Other _____	

### Patient Rights

This authorization may be revoked by me at any time by written notification to the individual or agency identified in (1) and (2) above, (see Privacy Notice). However, revocation cannot be retroactive.

I understand that I have the right to inspect the information to be disclosed & 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) & will no longer be protected by the federal privacy regulations.

I understand that I am not required to sign this authorization form & that SHC will not condition the provision of treatment or payment to me on the signing of this authorization. SHC 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, & hold harmless the individual or agency identified in (1) & (2) 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 / legal representative      Date      Witness      Date

\*Authorization is invalid unless received within 90 days of signature.

If authorized by patient's representative, state authority and relationship to patient

### TO BE COMPLETED BY THE PERSON RELEASING THE MEDICAL INFORMATION

Method of delivery <input type="checkbox"/> Mail <input type="checkbox"/> Hand Carry <input type="checkbox"/> Fax <input type="checkbox"/> Verbal	Fee: \$ _____
Processed by: _____	Date: ___/___/___

\* must be initialed by patient

\*\* must have a valid court order & subpoena