INSTRUCTIONS

1. Provide the name, local phone, dawg tag number, and date of birth for the patient whom the protected health information is regarding. All fields in this section are required for identity verification.

2. Indicate whether SIU SHS will be releasing, obtaining (receiving), or exchanging the protected health information and identify the other Agency /Facility/ Person involved with this request. If the authorization involves only departments within the SIU campus you may initial the associated departments provided under intra-organizational use.

3. Indicate the nature or type of records to be released. Select only the minimum necessary to fulfill the purpose of the request. Immunization records requests do not require a signature when it is impractical, provided the request is to meet school admission requirements.

4. Certain categories of information have additional protections under Illinois law due to the sensitive nature of the content. Initial any of the listed categories that you wish to EXCLUDE from this release. Please note that for Psychiatric and psychological records sensitive information will be included regardless of any exclusions indicated on this form.

5. Indicate the purpose of the release of information.

6. Indicate the date of service range that will include the information requested. Please note that information outside of the ranges provided will not be included. Choose all dates for mental health records.

7. Indicate the format of the information (i.e. paper copies, electronic copies, or verbal) and indicate your preferred method of delivery for your information. If electronic is selected for method of delivery, ensure you have provided the recipients fax number in section 2 OR an email address here. The email address will be used to provide the recipient a password protected secure link to the requested records.

8. Provide a date for which this authorization will no longer be valid. Note, the maximum length is one calendar year.

9. Review your patient rights as presented.

10. The signature of patient / consenting individual line should be signed by the authorizing party who is:
    a. The patient who is 12 years or older
    b. The parent or guardian of an individual 12-17, provided the individual does not object
    c. The guardian of a person 18 years or older and able to provide court order granting this

The verbal consent box is for internal use only.

Only if the signature is **NOT** the patient who is 12 years or older with whom the records are associated, the relationship and authority should be provided here.

Signature of witness is required only when Mental Health records (i.e. psychological or psychiatric) or Developmental Disabilities records are being requested.

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