



Southern
Illinois University
Carbondale

visit us on the web: www.shc.siu.edu

Release of Medical Information Authorization

Student Health Center

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

Primary Care: I understand that information in my primary care medical records concerning HIV treatment, status, mental, social health issues, drug/alcohol use will be released unless marked otherwise and initialed: HIV____ Mental/Social Health____ Drug/Alcohol____

Requested Method of Delivery

Mail Hand Carry Fax

Patient Rights

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.

Information to be Released **Initials**

Primary Care	
<input type="checkbox"/> Visit Notes	
<input type="checkbox"/> Billing Records	
<input type="checkbox"/> Radiology Report	
<input type="checkbox"/> Radiology Films	
<input type="checkbox"/> Laboratory Results	
<input type="checkbox"/> Dental Records	
<input type="checkbox"/> Immunization Records	
<input type="checkbox"/> Other _____	
Mental Health:	
<input type="checkbox"/> Psychiatric Evaluation*	
<input type="checkbox"/> Psychiatric Treatment*	
<input type="checkbox"/> Professional Testing*	
<input type="checkbox"/> Psychological Counseling Notes*	
<input type="checkbox"/> Wellness Visit Notes*	
AIDS/HIV and Alcohol/Drug:	
<input type="checkbox"/> AIDS/HIV Related Records*	
<input type="checkbox"/> Alcohol/Drug Records*	

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 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.

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
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*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**

Copy Fees: First copy is complimentary. Additional copies: \$20 handling fee and \$.50 per page. \$10.00 fee to transfer to CD. Additional postage fee for mailing copies. **For Counseling Center records please contact the Counseling Center at 618-453-5371**