Authorization for Release of Confidential Health Information

SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

Name: Last: _____
First: _____
Middle: _____
800 #: _____ Date of Birth: ___/___/___
Phone: _____
Address: _____
City: _____ State/Zip: _____

SIUE Counseling & Health Services
0222 Student Success Center
Campus Box 1055
Edwardsville, IL 62026-1055
Call 618-650-2842 Fax 618-650-5839

I hereby authorize SIUE Counseling and Health Services to (**CHECK APPROPRIATE BOX**):
□ RELEASE TO: □ RECEIVE FROM: □ EXCHANGE WITH:
Name: _____
Address: _____ City: _____ State/Zip: _____
Phone: _____ Fax: _____

SPECIFIC DATE(S) OF SERVICE TO BE RELEASED: _____

Please indicate specific information to be released. Blanket authorizations of unspecified information are not valid.
□ Visit notes _____ □ Lab results _____
□ Immunizations: _____ □ X-ray results or films _____
□ Depo Provera records- Date of last Depo injection, annual exam record, & most recent STI testing results.
□ Other _____

Diagnosis of Mental Health, Alcohol and Substance abuse, and AIDS/HIV are NOT included in a general information releases. Federal regulations outlined in the Code of Federal Regulations, 42 CFR, Ch. 1, Part 2 (1983), and Illinois 740 ILCS 110 require this information specifically indicated. **Releases for Counseling Service must allow the following authorizations**:

Please authorize release of specific information by initialing after the appropriate diagnosis.

Mental Health: _____ Alcohol & Substance Use: _____ AIDS/HIV: _____

Purpose for this disclosure:
□ Continuity of care □ Insurance □ Attorney/Legal □ Other: _____

I understand that I have the right to inspect and/or obtain a copy, (for an appropriate fee) of the information prior to disclosure. I may revoke this authorization at any time (except to the extent that action has already been taken) by submitting a written revocation to Southern Illinois University Edwardsville Counseling and Health Services. If I refuse to sign this authorization, my medical record/information will not be released. This authorization will be considered valid for a one year period following the date of signature unless otherwise specified here: _____ I absolve the individual or agency identified above and the Board of Trustees of Southern Illinois University Edwardsville together with its officers and employees from any legal liability, which may arise from the disclosure of this information.

Patient Signature: _____ Date: _____
Witness Signature: _____ Date: _____

OFFICE USE ONLY: □ Mail □ Hand Carry □ Fax
DATE NEEDED: Charge $ Processed by: Date processed:

Standard charge for releasing copies: $1 per page