

Authorization for Release of Confidential Health Information



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