AUTHORIZATION AND RELEASE OF INFORMATION

I hereby request and authorize that a representative from **The Southern Illinois University Edwardsville (SIUE) Office of Human Resources (HR)** contact the following health care provider:

Provider Name _____

Provider Telephone Number_____

to discuss my or my dependents' health/dental insurance benefits with SIUE, provided through the State of Illinois Department of Central Management Services (CMS).

The purpose of this request and authorization for release of information is being made to assist in my receipt of medical/dental services, and regarding payment therefor.

A copy of this release shall be considered to have the same authority as an original.

_____ _____

Employee Name (Printed) Date of Birth

_____ _____

Employee Signature Employee ID # (800 #)

_____

Dependent Name (Printed) if applicable

_____

Date