

600 Lincoln Avenue Charleston, IL 61920-3099 Office: (217) 581-3013 Fax: (844) 256-6402

## Authorization to Release Patient Information

Print Name		
E#Birthd	ate//Ema	il
Address		
Phone Number		
ALL Sections Must Be Complet	ed.	
I authorize Eastern Illinois Unive	rsity Health and Counsel	ing Services – Medical Clinic to
		patient records as directed below:
1) N		(-i1
1) Name and address of person		
Address (site state =: n).		Fax #
Address (city, state, zip):	:C\.	<del></del>
2) Purpose of disclosure (please	specify):	
3) Dates of Service: From		
4) Specific Records/Informatio		<b>N</b>
o Office Visit Notes		Mental health treatment/information
<ul> <li>Lab/Pathology Reports</li> </ul>	0	Verification of visit
o Radiology Reports	0	
<ul> <li>Immunization Records</li> </ul>		(specify)
<ul> <li>Billing Records</li> </ul>		. <del>-</del>
		ne release of the following information:
		as defined by statute and Illinois
	,	es venereal disease, tuberculosis,
hepatitis B, human immur	odeficiency virus "HIV,	" acquired immunodeficiency
syndrome "AIDS," and A	IDS related complex "Al	RC") and (specify other, if
known)		
<ul> <li>Alcohol and/or drug abuse</li> </ul>	treatment information p	protected under the regulations in 42
Code of Federal Regulation	ns, Part 2. (See "Importa	ant Notice" below).
		voked in writing at any time unless the
		nit your written request to the Medical
		zation expires 1 year after the date that
		wing specific date, event or condition:
it is signed by the patient represen	autive, or upon the folio	wing specific dute, event of condition.
7) Conv/Fees Lunderstand that	I can inspect and copy th	ne written information that is being
exchanged, that in the case of ora		
		ssing of this request. Please check with
staff for estimated costs.	ssociated with the proces	ssing of this request. Frease check with
starr for Estimated Costs.		

- 8) **Important Notice:** The confidentiality of alcohol and drug abuse patient records are protected by Illinois State Law (20ILCS 301) and federal laws and regulations (42 CFR, Part 2). The confidentiality laws and regulations prohibit the disclosure of these records unless:
  - 1. The patient consents in writing;
  - 2. The disclosure is allowed by court order;
  - 3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Violation of the laws and regulations is a crime. Suspected violations may be reported to appropriate authorities in accordance with the laws and regulations. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

My authorization to disclose the above information is voluntary, and the Medical Clinic will not condition the provision of treatment on this authorization. I further understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and in that event is no longer protected by the laws and regulations applicable to Eastern Illinois University, Health and Counseling Services – Medical Clinic, but would be protected by any privacy laws that apply to the recipient.

Authorized Personal Representative	Date	Relationship to Patient	
Witness*	Date		
*Witness signature required only for rele	ase of Mental Health	or Developmental Disability inform	ation.
OFFICE USE ONLY			
Release Given:			
Release Given: in person			
Release Given: in person phone (recorded	d by:	) (	)Date
Release Given: in person	l by:	) (	)Date
Release Given: in person phone (recorded	l by:	) (	

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION