

Authorization to Release Patient Information

Print Name _____
E# _____ **Birthdate** ___/___/___ **Email** _____
Address _____
Phone Number _____

ALL Sections Must Be Completed.

I authorize Eastern Illinois University Health and Counseling Services – Medical Clinic to **release/receive** (circle as appropriate) information in my patient records as directed below:

- 1) **Name and address** of person or organization **to/from** (circle as appropriate) whom disclosure is to be made: Name: _____ Fax # _____
Address (city, state, zip): _____
- 2) **Purpose of disclosure** (please specify): _____
- 3) **Dates of Service:** From _____ To _____
- 4) **Specific Records/Information to be disclosed:**
 - Office Visit Notes
 - Lab/Pathology Reports
 - Radiology Reports
 - Immunization Records
 - Billing Records
 - Mental health treatment/information
 - Verification of visit
 - Other (specify) _____
- 5) **By checking the box or boxes below**, you authorize the release of the following information:
 - Communicable disease and infection information, as defined by statute and Illinois Department of Public Health Rules (which includes venereal disease, tuberculosis, hepatitis B, human immunodeficiency virus “HIV,” acquired immunodeficiency syndrome “AIDS,” and AIDS related complex “ARC”) and (specify other, if known) _____
 - Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations, Part 2. (See “Important Notice” below).
- 6) **Revocation/Expiration.** This authorization can be revoked in writing at any time unless the Medical Clinic has already acted upon your request. Submit your written request to the Medical Clinic. Without expressed written revocation, this authorization expires 1 year after the date that it is signed by the patient/representative, or upon the following specific date, event or condition:

- 7) **Copy/Fees.** I understand that I can inspect and copy the written information that is being exchanged, that in the case of oral communication I have the right to be told what was exchanged. There may be a fee associated with the processing of this request. Please check with staff for estimated costs.

