Illinois State University, Student Health Services

AUTHORIZATION
(Illinois Provider)

Purpose: This form is used to authorize us to use or disclose protected health information or another person to disclose protected health information to us for the purpose stated.

SECTION A: Individual authorizing use and/or disclosure.

Name:_____E-mail:_____

Current Address:_____ City, State & Zip:_____

Telephone: (_ _ _) _ _ _ - _ _ _ _ UID #: 8 _ _ - _ _ - _ _ _ Date of Birth: _ _ - _ _ - _ _ _ _

SECTION B: I authorize Student Health Services/ Illinois State University to:

□ **Release to:** □ **Obtain from:**

Agency/Facility/Person: _____

Address: _____

City, State & Zip Code: _____

Phone No.: _____Fax No.: _____

SECTION C: Specific Records/ Protected Health Information to Disclose: (check all boxes that apply and initial all boxes that apply if pt. present on request) ** PLEASE INDICATE SPECIFIC DATE/S of RECORD/S and/or VISIT/S**

- ❑ Immunization _____ (initial)
- ❑ Allergy Records _____ (initial)
- ❑ Radiology Records / From: Date/s: _____ _____ (initial)
- ❑ Clinic Notes / From: Date/s: _____ _____ (initial)
- ❑ Physical Exam / From: Date/s: _____ _____ (initial)
- ❑ Laboratory Result / From: Date/s: _____ _____ (initial)
- ❑ Billing Records / From: Date/s: _____ _____ (initial)
- ❑ Pharmacy Records / From: Date/s: _____ _____ (initial)
- ❑ Verbal Communication Regarding: _____ _____(initial)
- ❑ Other (please specify): _____ _____ (initial)

❑ HIV/AIDS (as defined by Illinois Statute) – **will not be released unless specifically indicated.**
From: Date/s: _____/ _____ (initial)

❑ Alcohol and/or drug abuse treatment information protected under the regulations in 42 Code of Federal Regulations **– will not be released unless specifically indicated.**
From: Date/s: _____/ _____ (initial)

❑ Mental Health Records (as defined by Illinois Mental Health and Developmental Disabilities Confidentiality Act) - **will not be released unless specifically indicated.**
From: Date/s: _____/ _____ (initial)

SECTION D: Purpose of this Authorization:

- ❑ Continuing Medical Treatment
- ❑ Work Requirement
- ❑ Patient Request
- ❑ Volunteer Work
- ❑ Other (please specify): _____

No Conditions: This authorization is voluntary. We will not condition your treatment on this authorization. If you are temporarily prohibited from completing and signing this authorization for religious reasons, you will not have to do so at this time, but will complete it as soon as you are able to do so.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

However, any mental health, substance abuse, genetic testing, or HIV/AIDS information disclosed pursuant to this authorization may not be further disclosed except pursuant to your authorization.

If you are authorizing the disclosure of psychological tests, such tests may only be disclosed to a psychologist that you have designated.

SECTION E: Expiration and revocation

Expiration: **This authorization expires 365 calendar days after it is signed or upon the following specific date, event or condition:**

_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Illinois State University, Student Health Services
Patient Support Services
Campus Box 2540
Normal, IL 61790-2540
Telephone: (309) 438-7559
Fax: (309) 438-5205

INDIVIDUAL'S SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

If this authorization is for mental health records, this authorization must be witnessed below.

Signature: _____

Name: _____

Date: _____

Mail or Fax completed form to:
Illinois State University
Student Health Services
Attn: Patient Support Services
Campus Box 2540
Normal, IL 61790-2540
Phone: (309) 438-7559
Fax: (309) 438-5205

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's records.

For Office Use ONLY:

Signature verified by: ❑ Witness ❑ Comparison

Recipient ID verified by: ❑ Driver's License # _____ ❑ ISU ID

❑ Faxed Request by pt. / Copy of Driver's License or photo ID: attached and Fax # verified

Date released: _____ Released by: _____