Health Service
Eastern Illinois University

Authorization to Release Patient Information

EIU Health Service
600 Lincoln Avenue
Charleston, IL 61920
Phone: (217) 581-3013
Fax: (217) 581-3899
Email: health@eiu.edu

Print Name_____
E# _____ **Birthdate**____/____/____
Address_____
_____
Phone Number _____
Email _____

ALL Sections Must Be Completed.

I authorize Eastern Illinois University Health Service 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 Health Service has already acted upon your request. Submit your written request to the Health Service. 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.

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 Health Service 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 Service, but would be protected by any privacy laws that apply to the recipient.

_____ _____
Patient's Signature (or Parent/Guardian/Authorized Signature where applicable) Date

_____
Authority to Sign (relationship to patient)

_____ _____
Witness Required Date

OFFICE USE ONLY

Health Service
Eastern Illinois University

Release Given:

_____ in person
_____ phone (recorded by: _____) (_____)Date_____
_____ Fax (attached) second phone witness
_____ E-mail
_____ Mail

Records to be: Mailed Faxed Picked Up

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION