HEALTH & COUNSELING SERVICES
EASTERN ILLINOIS UNIVERSITY

Health and Counseling Services
600 Lincoln Avenue
Charleston, IL 61920
Immunizations@eiu.edu
Fax: 217/581-2010
Phone: 217/581-7786

Request/Authorization to Release Immunization Records

Individual Making Request

Print Name_____

Email _____

Address_____

Phone Number _____

Other Names/Alias Student May Go By: (Maiden Names, Preferred Names):

_____

Student E Number: _____

Student Date of Birth: _____

Month/Year Student First Attended EIU: _____ **Month/Year Last Attended EIU:** _____

Where and How Records Should Be Sent

_____ in person

_____ Fax: Please indicate individual, office/department, phone number and fax # :_____

_____ E-mail: Please indicate individual & e-mail address:_____

_____ Mail: Please indicate individual, address, state, zip:

_____

My authorization to disclose the above information is voluntary, and Health and Counseling Services 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, but would be protected by any privacy laws that apply to the recipient.

_____ _____
Student's Signature Date

If a minor or otherwise unable to sign this Authorization, the patient's Personal Representative must sign.

_____ _____ _____
Authorized Personal Representative Date Relationship to Patient

Request/Authorization to Release Immunization Records

OFFICE USE ONLY

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

FORMS/AUTHORIZATION TO RELEASE PATIENT INFORMATION
REV. 7/17/2024