HEALTH & COUNSELING SERVICES
EASTERN ILLINOIS UNIVERSITY

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

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 to **release/receive** (circle as appropriate) information in my patient records as directed below:

Name and address of person or organization **to/from** (circle as appropriate) whom disclosure is to be made:

Name: _____

Address (city, state, zip):_____

Phone:_____ Fax # _____

Purpose of disclosure (please specify):_____

Dates of Service: From _____ To _____

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)_____

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).

Revocation/Expiration. This authorization can be revoked in writing at any time unless the Health and Counseling Services has already acted upon your request. Submit your written request to the Health and Counseling Services. 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: _____

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.

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 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.

_____

Patient's Signature Date

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

_____ _____

Authorized Personal Representative Date Relationship to Patient

_____

Witness* Date

*Witness signature required only for release of Mental Health or Developmental Disability information.

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