SOUTHERN ILLINOIS UNIVERSITY
SCHOOL OF MEDICINE AND SIU HEALTHCARE (SIU)
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

_____ hereby give my consent to SOUTHERN ILLINOIS
(Name of Patient or Authorized Agent)

UNIVERSITY SCHOOL OF MEDICINE and_____
Name of Physician(s)

to release to _____
(Name of Health Care Facility, Physician, Agency, etc.)

_____
(Street Address) (City/State) (Zip)

Information contained in the medical record of _____
(Patient's Name) (Birthdate)

relating to medical care and treatment provided to the above named patient for the purpose of_____
_____

(e.g., **transfer of care, second opinion, patient treatment, disclosure to Insurance Co., other reason)**

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

❑ problem list
❑ list of allergies
❑ most recent history and physical
❑ laboratory results
❑ x-ray and imaging reports
❑ consultation reports
❑ entire report
❑ medication list
❑ immunization record
❑ Doctor/Specialty records only _____
from (date)_____ to (date) _____
from (date)_____ to (date) _____
from (doctor's names) _____
from (date)_____ to (date) _____

Other — specify dates of service or other materials to be released: _____
Special Instructions: (e.g. appointment date or pick-up date/time/location) _____

I authorize SIU School of Medicine to release sensitive information as indicated: The patient 12 or over who consented to the treatment must authorize the release of sensitive information.

❑ AIDS / HIV ❑ Drug / Alcohol Abuse ❑ Behavioral Health ❑ Genetic Information
❑ Sexual Assault ❑ Child Abuse ❑ Developmental Disabilities

I understand the following provisions:

- I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits.
- I understand that I have the right to revoke this authorization at any time, in writing, and must deliver the revocation to the SIU medical records department.
- I understand that the revocation will not apply to information that has already been released in response to this authorization.
- Any disclosure of information has the potential for an unauthorized redisclosure by the recipient and as such would no longer be protected by law**.
- If not otherwise specified, this authorization will expire in six months after it is signed.
- I can refuse to sign this authorization.
- I may inspect or copy the information to be used or disclosed as provided by law.

Signature of Patient or Consenting Individual_____Date_____

If signature is not of Patient, indicate relationship _____Date_____

Signature of Witness _____ Title _____Date_____

**NOTICE TO RECEIVING AGENCY/FACILITY/PERSON: You may not redisclose any records disclosed to you pursuant to the lllinois Mental Health and Developmental Disabilities Confidentiality Act (720 ILCS 110/ et seq.) or the federal Alcohol Drug Treatment regulations, (42 CFR 2 et seq.) unless the person who consented to this disclosure specifically consents to such redisclosure.