SIU Medicine
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

SIU MEDICINE

I, _____ hereby give my consent to SIU Medicine to release information as indicated above and below.
(Name of Patient or Authorized Agent)

Person requesting the disclosure:	**And is to be provided to:**
NAME	NAME OF PHYSICIAN(S), ATTORNEY, AGENCY, ETC.
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

Information contained in the medical record of:

PATIENT'S NAME	BIRTH DATE

Related 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**)

I authorize the following protected health information to be released and understand that my records may reference sensitive information including, but not limited to, mental health diagnoses/treatment, sexually transmitted infections, drug/alcohol abuse and HIV.

Please select the type of information you are authorizing for release:

☐ Office visit notes ☐ Laboratory reports ☐ Radiology reports ☐ Consultation reports ☐ Immunization record
☐ Pathology reports ☐ All test results ☐ Other _____

☐ Specific dates: from _____ to _____. If no date is provided, protected health information for the two year period prior to the date of this authorization will be released. We will not accept a release for future medical records.

☐ Specific Provider(s) or Specialty: _____

I authorize SIU School of Medicine to release sensitive information as indicated:

☐ AIDS/HIV ☐ Drug/alcohol/substance abuse ☐ Behavioral/mental health ☐ Consultation reports ☐ Genetic/IVF information
☐ Sexual assault ☐ Child abuse/neglect ☐ Developmental disabilities

Select how you would like this information released: ☐ US Mail ☐ CD or flashdrive

☐ Secure email _____ (please provide email address) ☐ Fax _____ (please provide fax #)

NOTE: Minors 12 through 18 years of age are required to sign and date the authorization when their mental health information and/or information regarding birth control services, pregnancy, treatment for sexually transmissible infections or drug or alcohol abuse treatment that the minor him/herself consented to, pursuant to Illinois state law, is being released.

I understand the following provisions:

- I understand that this authorization/consent is voluntary and that I may refuse to sign this authorization/consent. Unless allowed by law, my refusal to sign will not affect my ability to receive treatment, receive payment or eligibility for benefits.
- I understand that I have the right to cancel this authorization/consent at any time, in writing, and must deliver the revocation/cancellation to the SIU Medical Records Department.
- I understand that the revocation/cancellation will not apply to information that has already been released in response to this authorization/consent.
- Any disclosure/sharing of information has the potential for an unauthorized re-disclosure by the recipient and it would no longer be protected by law**.
- For any mental health information, only records of services up to the date of the signature on the authorization will be released while non mental health records will be released including service dates after the signature but before the expiration.
- I may inspect or copy the information to be used or disclosed/shared as provided by law. I understand I may be charged a fee for copies of records.

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 Illinois 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.

RETURN FORM TO:
201 E. Madison, Box 19641
Springfield IL 62794
Fax: 217-545-7880 | Email: roi@siumed.edu