SIU MEDICINE

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

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

UNIVERSITY MEDICINE and _____
Name of Physician(s)

to release to _____
(Name of Individual, 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)**

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, etc. Please check all boxes of the information you want to be released.

- ❑ History and Physical
- ❑ Laboratory Reports
- ❑ Radiology Reports
- ❑ Consultation Reports
- ❑ Pathology Reports
- ❑ Immunization record
- ❑ Abstract/Summary (Includes History & Physical, Operative and Consultation Reports
- ❑ All Test Results
- ❑ Other

Covering the period of healthcare from: Specific Dates _____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.

Disclosure Format (paper is default if not marked) __US Mail in paper format __Email in secure format ___CD/flashdrive __ to a healthcare provider's fax. _____

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

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

NOTE: Minors ages 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 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**.
- This authorization/consent will expire in six months after it is signed unless the request concerns mental health and/or developmental disabilities and then this authorization/consent is effective the date of the authorization/consent and shall then expire.
- 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 _____

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**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.

Revised & Approved by Legal, Breach Committee & Quality & Safety 2/2015 slc-7116703-1
Revised & Approved by Legal, Breach Committee & Quality & Safety 2-2015
Revised & Approved by: Quality, Risk, & Safety Committee: 5-15-2019,
Operational Clinical Performance Committee: 6-12-2019
Quality & Safety Committee: 6-18-2019