SIU MEDICINE

Authorization for the Release of Information

Name _____ Date of Birth _____

Address _____ City, State, Zip _____

Student ID _____ Phone Number _____

Email _____

I hereby authorize SIU School of Medicine to:

☐ Obtain Information From
☐ Release Information To

Name of Person or Agency _____

Relationship to Student _____

Address _____ City, State, Zip _____

Phone _____ Fax _____

PURPOSE OF THIS REQUEST: ☐ Document Accommodations ☐ Other

_____

TYPE OF RECORDS AUTHORIZED:

☐ Psychiatric/Psychological Evaluation ☐ Vision or Hearing Evaluation ☐ Medical/Treatment Records ☐ Other ☐ Accommodation(s)

_____

This authorization will expire:

◯ When the requested information has been sent/received
◯ One year from this date
◯ When I am no longer receiving services from DSS

I understand that:

- Signing this authorization is voluntary.
- I may cancel this authorization at any time by submitting a written request to Disability Support Services.
- This cancellation will not affect any disclosure that has already occurred.

Signature of Student: _____ Date: _____

Contact Information

SIU School of Medicine
Human Resources
Attn: Accommodation Requests
327 W. Calhoun Avenue
Springfield, IL 62711

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medstudentada@siumed.edu