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

medstudentada@siumed.edu