SIU HealthCare
Exceptional Medicine. Partners in Care.

SIU School of Medicine

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE (SIU) and SIU HEALTHCARE (SIU)

Patient Name _____ Health Record Number _____

Date of Birth _____ Telephone (____) _____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure to SIU:

_____

Address: _____

3. 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 record
- ☐ 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: _____

_____

4. I authorize the release of 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

Dr. Julie Fleischer

5. Special Instructions: (e.g. appointment date or pick-up date/time/location) _____

SIU HC Department of Pediatrics
P.O. Box 19611, Spfld, IL 62794-9661

FAX - 217-545-5018

6. 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 individual or organization providing the information.
- 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 re-disclosure 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 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 re-disclose 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 re-disclosure.

Revised & Approved by Legal, Breach Committee & Quality & Safety 2-2015