SOUTHERN ILLINOIS UNIVERSITY
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I, _____ hereby give my consent to _____,
(Name of Patient or Authorized Agent) (Name of Health Care Facility, Physician, Agency, etc.)

_____ to release to Risk Management Insurance Programs,
(Address)

Southern Illinois University, 1400 Douglas Drive, MC 6801, Carbondale, IL 62901, all information contained in the

medical record of _____ _____, relating to medical care and
(Patient's Name) (Birth Date)

treatment provided to the above named patient from _____ to _____ for the purpose of
(Date) (Date)

_____
(e.g., Investigation of Claim, Disclosure to Attorney, Disclosure to Insurance Company, etc.)

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ problem list	☐ medication list
☐ list of allergies	☐ immunization record
☐ most recent history and physical	☐ most recent discharge summary
☐ laboratory results	from (date) _____ to (date) _____
☐ x-ray and imaging reports	from (date) _____ to (date) _____
☐ consultation reports	from (doctor's name) _____
☐ entire record	from (date) _____ to (date) _____

Other:_____

Special Instructions:

_____

To the extent applicable, I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Risk Management Insurance Programs. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

SIGNED_____ DATE_____
(Patient or Authorized Representative)

If you are not the Patient, please specify your relationship to the Patient: _____

WITNESS_____ DATE_____