



Authorization for Release of Confidential Health Information

Name: (Last) _____ (First) _____

NIU ID _____ Date of Birth: ____/____/____ Phone#: (____) _____

Address _____ (City) _____ (State/Zip) _____

I hereby authorize Northern Illinois University Health Services to (CHECK APPROPRIATE BOX)

- RELEASE TO RECEIVE FROM EXCHANGE WITH

Name: _____

Address: _____ CITY _____ STATE, ZIP _____

Phone: (____) _____ FAX #: (____) _____

Please indicate specific information to be released. Blanket authorizations of unspecified information are not valid.

- Visit notes Lab results Immunizations X-ray results or films Mental Health (see box below) Other

Diagnosis of Mental Health, Alcohol and Substance abuse and AIDS/HIV are NOT included in a general information releases. Federal regulations outlined in the Code of Federal Regulations, 42 CFR, Ch. 1, Part 2 (1983), and Illinois 740 ILCS 110 require this information specifically indicated. Please authorize release of specific information by initialing after the appropriate diagnosis. Mental Health Alcohol and Substance abuse AIDS/HIV SPECIFIC INFORMATION TO BE RELEASED MUST BE INDICATED IN THE AREA ABOVE THIS BOX. BLANKET AUTHORIZATIONS OF UNSPECIFIED INFORMATION ARE NOT VALID.

Purpose for this disclosure: Continuity of care Insurance Attorney/legal Other

I understand that I have the right to inspect and/or obtain a copy, (for an appropriate fee) of the information prior to disclosure. I may revoke this authorization at any time (except to the extent that action has already been taken) by submitting a written revocation to Northern Illinois University, Health Services. If I refuse to sign this authorization, my medical record/information will not be released. If this is for the purposes of third part payment, the refusal to authorize could result in the assignment of financial responsibility to me, the patient, for services. This authorization will be considered valid for a 90 day period following the date of signature unless otherwise specified here. I absolve the individual or agency identified above and the Board of Trustees of Northern Illinois University together with its officers and employees from any legal liability, which may arise from the disclosure of this information.

Patient Signature: _____ Date: _____

Witness (required for Mental Health Information releases) _____

OFFICE USE ONLY: Method of Disclosure: Mail Hand Carry Fax DATE NEEDED: Processed by: Charge \$ No Charge Date: