

# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**Beu Health Center**

1 University Circle, WIU

Macomb, IL 61455

Phone (309) 298-1888

FAX (309) 298-2188

**PATIENT NAME (Please print):**

<i>Last Name</i>	<i>First Name</i>	<i>MI</i>	<i>Date of Birth</i>
<i>Address</i>			
<i>9-digit WIU Student ID #</i>		<i>Local Phone</i>	

**RELEASE FROM:**

**RELEASE TO:**

<input type="checkbox"/> Beu Health Center  <input type="checkbox"/> Name: _____	<input type="checkbox"/> Beu Health Center  <input type="checkbox"/> Name: _____		
<i>Address</i>	<i>Address</i>		
<i>City</i>	<i>City</i>		
<i>State</i>	<i>Zip</i>	<i>FAX</i>	
<i>State</i>	<i>Zip</i>	<i>FAX</i>	

**PURPOSE:**

**DATES OF RECORDS TO BE RELEASED:**

<input type="checkbox"/> Patient's Request <input type="checkbox"/> Continuing Treatment <input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Other : _____	From: ____/____/____    To: ____/____/____
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**SPECIFY RECORDS TO BE RELEASED:**

Allergy Records     X-ray report     X-ray CD     Physical Exam     Laboratory Results     Immunization records  
 TB tests     Clinic Notes     Other (Specify): \_\_\_\_\_

Entire Health Record (\$20.00 Charge applies). There is no charge to mail health record to another healthcare professional (e.g. physician). Entire health record will not be faxed.

**By initialing the boxes below, I am authorizing the release of the following information:**

Alcohol and/or drug abuse treatment information (as protected under 42 CFR)  
 HIV/AIDS Information (as defined by Illinois Statute)  
 Mental Health Records (as defined by the Illinois Mental Health and Developmental Disabilities Confidentiality Act)

This consent will terminate upon (specific date, event or condition): \_\_\_\_\_. I understand that I may revoke this consent at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer. **If no calendar date is specified above, Mental Health Records may only be released on the date this release is received by our office.**

**NOTICE TO PATIENT:**

I fully understand that my medical record and health information for the above date(s) may contain alcohol/drug abuse, and/or HIV/AIDS test results, mental health information and/or other information.\* I understand that any of the above selected records may contain medical information from outside sources and authorize Beu Health Center to release these records and health information if necessary for the continuity of care or if I have requested my complete record. I understand that I have the right to inspect and/or obtain a copy (for the appropriate fee) of my medical record prior to disclosure. I understand that this consent applies both to written and verbal release of information. I absolve, discharge, release, & hold harmless the Board of Trustees for Western Illinois University together with its agents and employee for any legal liability, claims, or damages which may arise from the disclosure of this information.

\* To receiving agency: these records may not be re-disclosed without the patient's consent.

\_\_\_\_\_  
Signature of patient or authorized legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient, if signed by authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness signature (required for mental health/HIV/substance abuse)

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY:**

Date prepared:	Date Mailed/Faxed:	Date given to student:	Fee:
Initials:	Initials:	Initials:	Green Task Completed?