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):

Last Name	*First Name*	*MI*	*Date of Birth*

Address	

9-digit WIU Student ID #	*Local Phone*

RELEASE FROM:

☐ Beu Health Center

☐ Name: _____

Address	*City*	
State	*Zip*	*FAX*

RELEASE TO:

☐ Beu Health Center

☐ Name: _____

Address	*City*	
State *Zip*		*FAX*

PURPOSE:

☐ Patient's Request ☐ Continuing Treatment
☐ Legal ☐ Insurance ☐ Other :

DATES OF RECORDS TO BE RELEASED:

From: _____/_____/_____ To: _____/_____/_____

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 <u>initialing</u> 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. **<u>If no calendar date is specified above, Mental Health Records may only be released on the date this release is received by our office.</u>**

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?