

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**Student / Patient Information:**

Patient Name: \_\_\_\_\_ CWID: \_\_\_\_\_  
Address: \_\_\_\_\_ D.O.B: \_\_\_ / \_\_\_ / \_\_\_  
\_\_\_\_\_ Gender: \_\_\_\_\_  
Phone: ( \_\_\_ ) \_\_\_\_\_ Date of entry: \_\_\_ / \_\_\_ / \_\_\_  
Email: \_\_\_\_\_ Date of Graduation: \_\_\_ / \_\_\_ / \_\_\_  
Student Status:  Undergraduate  Graduate

**The information is to be released to:**

Name: \_\_\_\_\_ Organization: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: ( \_\_\_ ) \_\_\_\_\_  
\_\_\_\_\_ Fax: ( \_\_\_ ) \_\_\_\_\_  
Release the following Information:  
 Immunization Records  Medical File  Other: \_\_\_\_\_

**Authorization and Signature: (for the Use and Disclosure of Protected Health Information)**

I \_\_\_\_\_ do hereby authorize IIT Student Health Center to disclose my protected health information as described above. I understand that the information I authorize to be released may be re-disclosed and no longer protected by the Federal Privacy Regulations. I understand that this consent may be revoked at anytime by submitting a written request to do so. Any such revocation shall have no effect on disclosures made prior to the date the revocation is received. I understand that I have the right to inspect and copy the information disclosed and that this authorization is valid for 90 days after the date signed.

**I also accept the risk and consequence of faxing medical records**

**Sensitive Information**

This authorization is for full disclosure of all records, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of health care personal, dates of visits and treatment. This may even include information regarding mental health, developmental disability, alcohol or drug use, and infectious disease including sexually transmitted diseases, HIV/AIDS. Such records will be disclosed unless you specifically indicate information you do not want released. If you do not wish such information to be released, state information to be excluded here:

\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Guardian Signature (if under 18)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date