UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE AT ROCKFORD

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION

PATIENT LABEL HERE

Patient's name (PRINT) ______________________________ DOB ____________
Last First Middle initial Month/Day/Year

Patient's Telephone Number (________)________________________ Number where you can be reached if questions arise.

The undersigned below requests: **South Beloit School Based Health Center**

Requests information to be: Released to

University School Based Health Center at South Beloit

Release only those portions of the record checked below:

Abstract Only*	( )	Entire Record	(X)	Immunization Record	( )
Laboratory Report(s)	( )	Types and Dates of Lab Reports ______________			
Radiology/US	( )	Types and Dates of Other Reports ______________			
Other	( )	Specify ______________			

*Abstracts includes the requested information from the date of service, the problem list and medication list.

The purpose/need for records/information: **Continuance of Care**

I fully understand that: my medical record and/or information in connection with the hospitalization/treatment date(s) stated above may contain mental health, development disabilities, alcohol and drug abuse records, and/or testing, treatment related to AIDS or HIV information. The medical records and/or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only on my authorization, except as required by law. Only such records and/or information believed necessary for the purpose expressed above shall be released and disclosed. I may revoke this authorization at any time (except to the extent action has already been taken in good faith reliance on this authorization) by submitting a written revocation request to the Medical Record Department. If I refuse to sign this authorization, my medical record/information will not be released. I understand that if this authorization is for the purpose of third party payment, that diagnostic and therapeutic information as may be necessary to process benefits will be disclosed and that refusal to authorize for this purpose will result in the assignment of financial responsibility to me for services rendered and that I will be billed to these services. No other adverse consequences to me will result if I refuse to sign this authorization. I agree to release and hold harmless the office, its directors, officers, employees, successors, agents, assigns, and any and all members of its medical staff, from and against any and all liability, damages, claims, or suits, including reasonable attorneys' fees, in connection with the disclosure of records/information as authorized herein.

This authorization expires on ______________________ or one year from the date of signature.

*Patient signature ______________________________ *Date ____________
(if other than patient, state relationship)

*Witness signature ______________________________ *Date ____________

Parent signature (ages 12-17) ______________________________ Date ____________
(relationship to patient)

*Required for patients ≤17 years of age.

OFFICE USE ONLY

Date Received: ____________ Patient MRN: ____________

Date Released: ____________ Released by: ________ Information Released (or comments): ______________________

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