UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE
AT ROCKFORD

AUTHORIZATION FOR HEALTH INFORMATION RELEASE / MEDICAL TREATMENT RELEASE

☐ South Beloit School Based Health Center
☐ Blackhawk Park School Linked Health Center (Rockford)

Student's name_____Grade _____ ID number_____

Today's date _____ ☐ Male ☐ Female Date of birth _____

Authorization for Health Information Release

I authorize release of information from the medical record, to the health professional or health center designated by me whenever necessary for care including referral and/or emergency services.

I authorize release of information regarding treatment to third party payers such as Medicaid or others for the purposes of billing or for any other reason in accordance with acceptable medical practice according to the law. **As applicable for students:** I further give consent for this information to be used in connection with the National Evaluation of the Healthy Schools, Healthy Communities Initiative.

I authorize the release of my child's immunization record and a copy of any Certificate of Child Health Examination form

completed by (name of school) _____.

I authorize (name of school) _____,

to release health records to _____.

To have access to medical records, a written release must be completed by the patient. This practice conforms with Illinois Law guiding all medical facilities. I understand this consent and authorization will remain in effect while the patient is enrolled in the health center, or until transitioned to another health care provider. **As applicable for minors:** It is the parent's responsibility to notify the health center about changes in guardianship.

Authorization for Health Information Release

_____ Name of Responsible Party (Print)

_____ Name of Minor (Print)

_____ Signature of Responsible Party

_____ Signature of Minor (if 12 years or older)

_____ Provider Review Signature

_____ Date