UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE AT ROCKFORD
RELEASE OF INFORMATION FORM

PATIENT LABEL HERE

Patient's name (PRINT): _____ **DOB:** _____
Last First Middle initial Month/Day/Year

Patient's Telephone Number: (_____)_____-_____ Where you can be reached if questions arise.

REQUESTS INFORMATION TO BE ☐ Released to: ☐ Obtained from: ☐ Exchange information with:

University Family Health Center
1221 E. State Street
Rockford, IL 61104
Phone (815) 972-1000/Fax (815) 972-1086

REQUESTS INFORMATION TO BE ☐ Released to: ☐ Obtained from: ☐ Exchange information with:

Name: _____

Address: _____

City, State, Zip _____

Phone (_____)_____-_____ Fax (_____)_____-_____

The purpose of this disclosure: ☐ Continued medical care ☐ Legal ☐ Personal ☐ Insurance ☐ Other (specify): _____

This access is limited to information designated below:
Type of encounter: ☐ Outpatient Date(s) _____

Release only those portions of the record checked below:
☐ History/physical ☐ Pathology report ☐ Immunizations ☐ Laboratory reports
☐ Operative report ☐ Other _____
☐ Entire record – **must specify dates** _____

I authorize the University of Illinois to release sensitive information as indicated:
The patient age 12 or over who consented to the treatment must authorize the release of sensitive information.
☐ AIDS/HIV ☐ Drug/alcohol abuse ☐ Behavioral health ☐ Genetic information
☐ Sexual assault ☐ Child abuse ☐ Developmental disabilities

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.
I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by federal privacy regulations.

This authorization will expire on _____ or within 90 days of the date of signature.

_____ _____
Patient Signature Date

_____ _____
Legal Representative Signature Relationship to Patient

_____ _____
Witness Signature Relationship to Patient

OFFICE USE ONLY
Date Received: _____ **Patient MRN:** _____

Date Released: _____ **Released by:** _____

Information Released (or comments): _____

_____

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