Client # _____

AUTHORIZATION TO RELEASE/EXCHANGE/OBTAIN CONFIDENTIAL INFORMATION

I, _____ hereby authorize the
(printed name of client and authorized agent if signing)

CLINICAL CENTER, SOUTHERN ILLINOIS UNIVERSITY CARBONDALE

to

___exchange with ___release to ___obtain from

[Client/agent must initial appropriate space(s) to indicate if information is to be exchanged, released or obtained]

_____
(Name of Health Care Facility, Physician, Agency, Etc.)

_____
(Address)

all information contained in the clinical file of_____
(Client)

_____, relating to services provided to the above named client
(Birth Date)

from_____ to _____ for the purpose(s) of:
(Date) (Date)

(1)_____

(2)_____
(e.g., transfer of care, disclosure to attorney, disclosure to insurance company, etc.)

The type of information to be used or disclosed is as follows:

NOTE: The client/agent must initial each checked area for this to be a valid authorization.

		EXPIRES month/day/year	**Initials**
o	Assessment results	_____/_____/_____	_____
o	Behavioral observations	_____/_____/_____	_____
o	Legal records	_____/_____/_____	_____
o	Treatment summary	_____/_____/_____	_____
o	Academic records	_____/_____/_____	_____
o	Medical records	_____/_____/_____	_____
o	Treatment attendance/compliance	_____/_____/_____	_____
o	Intervention treatment plan	_____/_____/_____	_____
o	Billing	_____/_____/_____	_____
o	Scheduling	_____/_____/_____	_____
o	Other (please specify) _____	_____/_____/_____	_____

Special Instructions: (e.g. appointment date or pick up date/time/location):

_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Clinical Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with a right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
(Same Date as Expire Date Above)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact SIU's privacy officer.

SIGNED_____ DATE_____
Client or authorized representative - Patient 12 years of age or under, Parent or Legal Guardian

If you are not the Client, please specify your relationship to the Client: _____

WITNESS_____ DATE_____

12/19/18