Client # _____

AUTHORIZATION TO RELEASE/EXCHANGE/OBTAIN CONFIDENTIAL INFORMATION

I, **Client's/Agent's name printed here** hereby authorize the

CLINICAL CENTER, SOUTHERN ILLINOIS UNIVERSITY CARBONDALE

to

Initials of Client/Agent on line that coincides with the request below: (Choose One)

___exchange with ___release to ___obtain from

Name of person/facility to which this information is to be exchanged, released or obtained

Address, phone number, fax number for person/facility above

all information contained in the clinical file of : **Client's Name Printed**

Client's date of birth, relating to services provided to the above named client

From **This must be a date** to **This must be a date** for the purpose(s) of:

(1) **Whatever the reason may be**
(2) **Whatever the reason may be**
(e.g., transfer of care, disclosure to attorney, disclosure to insurance company, etc.)

The type amount 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	Other (please specify	_____/_____/_____	_____

Make Expires Date one year from today

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 the 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 old or less, Parent or Legal Guardian

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

WITNESS **The Witness must be someone that signs when the client/agent signs** DATE _____

9/17