Q1		
Client #		
CHCHLH		

## AUTHORIZATION TO RELEASE/EXCHANGE/OBTAIN CONFIDENTIAL INFORMATION

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

## CLINICAL CENTER, SOUTHERN ILLINOIS UNIVERSITY CARBONDALE

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** 

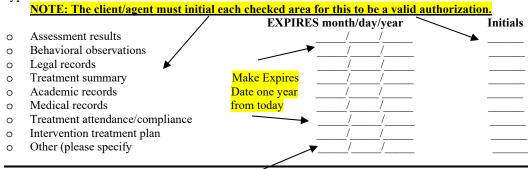
Client's date of birth, relating to services provided to the above named client

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:



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 th	e Client:	

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