CONFIDENTIAL

The Center for Health and Counseling Services
Lewis University, Mother Teresa Hall
One University Parkway
Romeoville, IL 60446
Telephone: (815) 836-5455
Fax: (815) 836-5047

Release of Information Authorization Form

Name: _____ Student ID#: _____

Graduation Date/Last Semester Attended: _____ Date of Birth: _____

I authorize the professional staff at the Center for Health and Counseling Services of Lewis University, Romeoville, Illinois to release and exchange information, either oral or written with the following:

_____
Name of individual(s) or practice

_____
please provide complete address

_____ _____
telephone number fax number

The author%Immunization records

Medical records

Professional summary of diagnosis and treatment

Other: Please describe the specific nature of information to be disclosed. _____

_____

_____

This authorization will expire on this date: _____
(date is not to exceed one year)

Purpose of Disclosure: _____

Refusal to consent to disclosure or release of this information may result in:

____ Delay in service ____ Limited treatment coordination ____ Limited continuity of care

____ Other, specify: _____

I understand that if persons or organizations I authorize to receive, use, or send the protected health information described above are not health plans, covered health care providers, or health care clearing-houses subject to federal health information privacy laws, they may further disclose my health information which may no longer be protected by federal law. I understand that I have the right to inspect and copy the informat Student Signature: Date:

_____ _____

Witness Signature: _____ Date: _____

A facsimile or photocopy shall maintain the same legal weight as the original. Revised 01/28/2011