



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 authorization includes the following information:

- Confirmation of contact with the Center for Health and Counseling Services
- 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 information to be disclosed.

I understand that this authorization is voluntary and made to confirm my consent. I also understand I may revoke this authorization in writing at any time; however, I realize such revocation will not affect information that may have been released while the original consent authorization was in force, and that a written notice of revocation will only prevent subsequent information from being released.

Student Signature: _____ Date: _____

Witness Signature: _____ Date: _____