



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: _____