Authorization for Release of Confidential Health Information

Northern Illinois University
Your Future. Our Focus.

Immunization Compliance & Records
Health Services Building, 2nd floor
DeKalb, Illinois 60115-2828
815-753-9585, 815-753-9578
Fax 815-753-9599
ImmunizationRecords@niu.edu
www.niu.edu/health-services

Name (Last) ________________________________

(First) ________________________________

(Maiden) ________________________________

NIU Z-ID________________ Date of Birth____/____/______
month day year

Phone ________/______________________

Address ______________________________ (City)______________ (State/Zip) ___________

I hereby authorize Northern Illinois University, Immunization Compliance and Records office to **(CHECK APPROPRIATE BOX)** ☐ RELEASE TO: ☐ RECEIVE FROM:

Name:____

Address:_________________________________ CITY ________________ STATE, ZIP ___________

Phone: (_______) ____________________________ FAX #: (_______) ___________________________

Email address: ____

Please check the information to be released and the specific date(s) of service. If dates are not included only the most recent information will be released.

☐Visit notes ______________________________ ☐Lab results ______________________________
☐Immunizations ___________________________ ☐X-ray results or films________________________
☐Other____

Diagnosis of Mental Health, Alcohol and Substance abuse and AIDS/HIV are NOT included in a general information releases. Federal regulations outlined in the Code of Federal Regulations, 42 CFR, Ch. 1, Part 2 (1983), and Illinois 740 ILCS 110 require this information specifically indicated. Please authorize release of specific information by initialing after the appropriate diagnosis.

Mental Health____________ **Alcohol and Substance abuse** ____________ **AIDS/HIV**______________

SPECIFIC DATE(S) OF SERVICE TO BE RELEASED:

Purpose for this disclosure: ____

I understand that I have the right to inspect and/or obtain a copy, (for an appropriate fee) of the information prior to disclosure. I may revoke this authorization at any time (except to the extent that action has already been taken) by submitting a written revocation to Northern Illinois University, Immunization Compliance and Records office. If I refuse to sign this authorization, my health information will not be released. This authorization will be considered valid for a 90 day period following the date of signature unless otherwise specified here________. I absolve the individual or agency identified above and the Board of Trustees of Northern Illinois University together with its officers and employees from any legal liability, which may arise from the disclosure of this information.

Patient Signature:______________________________________ Date:______________________

Witness (required for Mental Health Information releases) ______________________________________

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, (IL.Rev. Stat., ch. 91 ½, par 801 et seq.) you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.

OFFICE USE ONLY: ☐Mail ☐Hand Carry ☐Fax ☐Email
DATE NEEDED: ____________________Charge $___________Processed by:_____________Date Processed_____________