DOMINICAN UNIVERSITY

WELLNESS CENTER

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

7900 W. Division Lower Level Coughlin Hall River Forest, IL 60305
Fax: 708-488-5072 Phone: 708-524-6229

I, _____(Name of Student/Patient.) authorize Dominican University

- o to release to
- o and/or obtain from:

_____

Name and Address of individual or organization to which disclosure is to be made or who will be providing information.

The relevant information from the medical record of: _____, (Name of Student/Patient)

Whose birth date is ___/___/_____and whose Dominican Student ID number is: _____;

Compiled for the time period of _____ to _____.

The information is being requested for the purpose of_____.

RECORDS TO BE DISCLOSED

For a complete release of records, please initial Part I.
For a partial release of records, initial exceptions in Part 2 or 3.

Part 1. _____ All medical records, including records concerning any mental health and developmental disabilities, alcohol, and drug abuse records and HIV testing.

Part 2. _____ All medical records **excluding** information pertaining to:

_____ Mental Health and Counseling
Initials Initials
Date _____

_____ Health and Developmental disabilities
Initials Initials
Date _____

_____ Alcohol and drug abuse records
Initials

_____ HIV testing
Initials

Part 3. _____ Release **Immunization Record only.**

____Release information to Body Balance program only

_____ Release **Mental Health Records only.**

____Release information to nutrition counseling program only

Part 4: ____ Confirm attendance dates at _____ only.

DISCLOSURE INFORMATION

I understand that my records are protected under law and cannot be disclosed without my written permission unless otherwise provided by statutes or regulations. I have the right to revoke this consent by written statement at any time prior to release. I understand I have the right to inspect and copy the information to be disclosed although in certain instances applicable states or regulations may place restrictions on this right. No information released shall be re-disclosed to other individuals or agencies. This consent expires one year from the date signed, unless earlier revoked by me in writing.

Student/Patient's Signature _____Date_____

Witness who can verify identity of student/patient: _____Date: _____

(If patient unable to sign, state reason and relationship of person signing for student/patient.)
Reason: _____Relationship_____

(In attached and notarized document, state legal relationship to student/patient and legal basis on which consent is given.)

Parent/Legal Guardian: _____Date: _____

Witness who can verify identity of the patient: _____Date: _____

Rev: 1/25/2011