Bradley University Student Health Center 819 N. Glenwood Ave – Markin Center, Peoria, IL 61625 Telephone: (309) 677-2700

Fax: (309)677-3534

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Bradley Health Center to <u>RELEASE/OBTAIN</u> the relevant medical record information of:			
	DOD /	,	CCN
Name of Patient	DOB/_ MO_DA		SSN
I approve the release of medical records dated fro			to / /
	MO DATE		MO DATE YEAR
To/From the following individuals or organization_			
AddressFa			
RECORDS TO BE DISCLOSED			
Please initial one of the following choices:			
All medical records, including records concerning any mental health and developmental			
disabilities, alcohol and drug abuse records and HIV testing			
All medical records pertaining to (please choose from the following):			
Health Records			
Immunization Records			
Health Records pertaining to a specific medical condition			
(please specify)			
Mental Health Records			
Alcohol and Drug Abuse Records			
HIV testing			
DISCLOSURE INFORMATION			
I understand that my records are protected under law and cannot be disclosed without my written permission			
unless otherwise provided by statues or regulations. I have the right to revoke this consent by written statement			
at any time prior to release. I understand that I have the right to inspect and copy the information to be disclosed			
although in certain instances applicable states or regulation my place restrictions on this right. No information			
released shall be disclosed to other individuals or agencies. This consent expires in ONE YEAR from the date			
signed below unless earlier revoked by me in writing.			
Patient's Signature:			Date:
Parent/Legal Guardian:			Date:
Witness who can verify identity of patient			Date:
This is my written request to revoke the release.			
Patient Signature:			Date revoked: