The University of St. Francis
Health Services
500 Wilcox St., Joliet, IL. 60435

HIPAA AUTHORIZATION FORM

I, _____, whose date of birth is _____,
authorize **University of St Francis Health Records** to submit a copy of my health records to:

_____

Phone: ( )
Fax: ( )
Contact person:

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed.)

____ Immunization Health Records

____ Complete Health Record

Purpose

_____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to **Carlos Aquino-Director of Counseling and Health Services** at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on ____/__/___,
(*Expiration date is one year from date of signature*)

Conditions

I understand that failure to sign this authorization may have the following consequences:
Health Records will not be released without signature.

Redislcosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure

is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

I will be given a copy of this authorization for my records.

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual.

_____

_____

_____ Check here if client refuses to sign authorization.

_____

Staff Signature Date
Health Records
University of St. Francis