LOYOLA UNIVERSITY CHICAGO

Preparing people to lead extraordinary lives

WELLNESS CENTER
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name (**Please Print):** _____ Date of Birth: _____
SS#/Student ID#: _____ Phone #: _____

STATUS

☐ **Currently Enrolled** ☐ **Graduate**_____ ☐ **Transferred**_____
Date of Graduation **Last Date of Attendance**

COPIES WILL BE AVAILABLE IN 5-7 WORKING DAYS.

Check off one: Mail_____ fax_____ Pick-up at Lakeshore campus _____ Pick-up at Water Tower campus_____

I AUTHORIZE THE WELLNESS CENTER TO RELEASE TO:

Name: _____ Fax: _____
Address: _____ Phone: _____

THE FOLLOWING INFORMATION FROM THE ABOVE NAMED PATIENT'S RECORD
Please check off appropriate box(es). Please be as specific as possible:

☐ Gynecology Report(s) ☐ Pap Test ☐ Progress Report(s) ☐ Psychiatric or Mental Health Information
☐ Immunizations/TB Tests ☐ X-Ray Report(s) ☐ Physical Examination ☐ Drug/Alcohol Information
☐ HIV/AIDS Information
☐ Lab Report(s) Specify Test_____
☐ Other _____
Dates/Names of treatment/tests: _____

FOR THE FOLLOWING PURPOSE(S) (Please check off appropriate boxes)

☐ Continuing Medical Care ☐ Third Party Reimbursement ☐ Other _____

NOTICE TO PATIENT

I fully understand that my medical record for the above date may contain psychiatric/developmental disability, alcohol/drug abuse, and/or Acquired Immune Deficiency Syndrome/HIV test results and/or information. I understand that I have the right to inspect and/or obtain a copy of the information prior to disclosure. I understand that this consent is valid for 60 days from the date of signature, or until calendar date _____, I understand that I may revoke this consent at any time by giving written notice to the Wellness Center at Loyola University Chicago. I understand that if I do not sign this authorization one consequence will be that the information will not be released. I absolve Loyola University Chicago and its agents, trustees, officers, and employees from any legal liability which may arise from the disclosure of this information.

To Receiving Agency: These records may not be redisclosed without the patient's consent.

_____ _____
Signature of patient or authorized legal guardian Date

_____ _____
Relationship to patient, if signed by authorized representative Date

_____ _____
Witness Date

_____ _____
Signature of staff member who received form at LUCWC Date

For Office Use Only

Date Mailed/Faxed_____ Date of Pick-Up_____
By Whom (Please Initial)_____ By Whom (Please Initial)_____

Lakeshore Campus Location: 6439 N Sheridan Road, Suite 310 • Chicago, IL 60626 • Phone: (773) 508-2530 • Fax: (773) 508-8790
Water Tower Campus Location: 26 E Pearson, Suite 250 • Chicago, IL 60611 • Phone: (312) 915-6360 • Fax: (312) 312-6362