



Authorization for Release Of Confidential Health Information

Name: (Last) _____ (First) _____
 Social Sec # _____ / _____ / _____ Date of Birth _____ / _____ / _____
 Phone # _____

INFORMATION FROM:

- Northern Illinois University, Athletic Training
- OR**
- Name _____ Phone# _____
 Address _____ Fax# _____

INFORMATION TO:

- Northern Illinois University, Athletic Training
- OR**
- Name _____ Phone# _____
 Address _____ Fax # _____

METHOD OF DISCLOSER: Fax Mail Hand Carry Verbal

PRIMARY CONTACT INFO:
 Northern Illinois University
 Head Athletic Trainer
 Huskie Stadium
 Athletic Training Room
 DeKalb, IL 60115

(815) 753-0211 Office

(815) 753-2415 Fax
 or
 (815) 753-1402 Fax

Information to be Disclosed: _____

Purpose for Disclosure: _____

Please indicate information to be released:

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergy _____ | <input type="checkbox"/> Mental Health _____ | <input type="checkbox"/> NCAA Notes _____ |
| <input type="checkbox"/> Diagnosis of Visit _____ | <input type="checkbox"/> Nutrition _____ | <input type="checkbox"/> X-Ray films _____ |
| <input type="checkbox"/> Gynecology _____ | <input type="checkbox"/> Medical/Injury Notes _____ | <input type="checkbox"/> X-Ray results _____ |
| <input type="checkbox"/> Lab results _____ | <input type="checkbox"/> Physical Therapy _____ | |
- Other _____

Diagnosis of Mental Health and/or Alcohol and Substance abuse are NOT included in a general release. Federal regulations outlined in the Code of Federal Regulations, 42 CFR, Ch. 1, Part 2 (1983), and Illinois 740 ILCS 110 require Mental Health and/or Alcohol and Substance abuse information specifically indicated if needed.

This information is to be used for the purpose of continuity of health care and treatment. 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, Athletic Training. If I refuse to sign this authorization, my medical record/information will not be released. If this is for the purposes of third part payment, the refusal to authorize could result in the assignment of financial responsibility to me, the patient, for services. This authorization will be considered valid for a 1 year 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.

Student-Athlete Signature: _____ Date: _____

Witnessed by: _____