

UNIVERSITY OF ILLINOIS  
AT SPRINGFIELD

Campus Health Services  
Division of Student Affairs  
Business Services Building, Room 20  
One University Plaza, MS BSB 20  
Springfield, IL 62703-5407

AUTHORIZATION FOR RELEASE OF INFORMATION

I \_\_\_\_\_ authorize \_\_\_\_\_ to release  
(name) (Clinic, physician, person, etc.)

\_\_\_\_\_  
(specific nature of information to be disclosed)

To \_\_\_\_\_  
(Receiving clinic, physician, etc.)

for the purpose of \_\_\_\_\_  
(evaluation, treatment, consultation, etc.)

This consent is valid until: \_\_\_\_\_  
(No more than 90 days)

I understand that I may revoke this authorization at any time and that the above-mentioned person authorized to receive this information has the right to inspect and copy the information to be disclosed.

It has been explained to me that if I refuse to consent to this release of information, the following are consequences:

\_\_\_\_\_  
(Specify, if any)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date)

**UIS**

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