

THE SCHOOL OF THE ART INSTITUTE OF CHICAGO



health services
Office of Student Affairs

Mailing address:
School of the Art Institute of Chicago
Health Services Department
Attention: HS Medical Releases
112 South Michigan Avenue
Chicago, IL 60603
Phone: 312.499.4288
Fax: 312.499.4290

RELEASE OF INFORMATION FORM

Student's Name (Please Print) _____ DOB _____

Year Entered SAIC _____ Student ID # _____

Phone # _____ Check One: Mail Fax Pick-Up

Copies will be made available in 5-7 business days.

I AUTHORIZE THE HEALTH SERVICE TO RELEASE TO:

Name _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip code _____

THE FOLLOWING INFORMATION FROM THE ABOVE NAMED PATIENT'S RECORD

Please check off as necessary. Be as specific as possible:

Immunizations/TB Tests Physical Examination Other (specify) _____

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 other 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 90 days from the date of signature. I understand that I may revoke this consent at any time by giving written notice to the Health Services Department at the School of the Art Institute of Chicago. I absolve the School of the Art Institute of Chicago and it's agents or employees from any legal liability which may arise from the disclosure of this information.

Signature of patient or authorized legal guardian Date

Signature of staff member who received form at SAIC Health Services Date

For Office Use Only -----

Date Mailed/Faxed/Given to Student _____ By Whom (please initial) _____