Office of Student Affairs | Health Services

116 S. Michigan Ave, 13th Floor, Chicago, IL 60603 312.499.4288

AUTHORIZATION FOR RELEASE OF INFORMATION FROM SAIC, Health Services

I,____________________________________ ____
Last Name **First Name**

Date of Birth_____________________________ **Student ID#**______________________________

Address____
Street **City** **State** **Zip Code**

Phone: (____) ________________

HEREBY AUTHORIZE AND REQUEST SAIC HEALTH SERVICES TO PROVIDE INFORMATION TO:

Name____

Address____
Street **City** **State** **Zip Code**

Phone____**Fax**____________________________

This information will be used for the purpose of:
____
and is confined to the following ***specified information*** **(initial all that apply)**:

_____ History and Physical
_____ Progress Notes
_____ Laboratory/Pathology Reports
_____ Mental Health Screening and Treatment
_____ Immunizations/TB test
_____ Other (specify below):

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 one year 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 its 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 Witness **Date**

--For office use only---

Date mailed/faxed/given to student______________________________**By whom (please initial)**___________