Northern Illinois University Physical Therapy Clinic

3100 Sycamore Road DeKalb, IL 60115

Phone: (815) 753-2600 • Fax: (815) 752-3299

Authorization for Release of Confidential Health Information

Name: (Last) _____ (First) _____

Address: _____ City:_____ State: _____Zip: _____

Date of Birth: _____ Phone Number: (_____) _____

I hereby authorize Northern Illinois University Physical Therapy Clinic to (Check Appropriate Box Below)

☐ RELEASE TO ☐ RECEIVE FROM ☐ EXCHANGE WITH

Name/Organization: (Last) _____ (First) _____

Address: _____ City:_____ State: _____Zip: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Please indicate specific information to be released. Blanket authorizations are not valid.

☐Test Results _____ ☐Reports _____

☐Treatment Notes_____ ☐Medications _____

☐Recommendations _____ ☐Other _____

☐Mental Health (see box below) _____

Diagnosis of Mental Health, Alcohol and Substance Abuse and AIDS/HIV are NOT included general information releases. Federal regulations outlined in the Code of Federal Regulations, 42 CFR, Ch. 1, Part 2 (1983), and Illinois 740 ILCS 110 require this information specifically indicated.

Please authorize release of specific information by initialing after the appropriate diagnosis.

Mental Health_____ Alcohol and Substance abuse _____ AIDS/HIV_____

SPECIFIC INFORMATION TO BE RELEASED MUST BE INDICATED IN THE AREA ABOVE THIS BOX. BLANKET AUTHORIZATIONS OF UNSPECIFIED INFORMATION ARE NOT VALID.

Purpose for this disclosure:

☐Continuity of Care ☐Insurance ☐Attorney/Legal ☐Other _____

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 Physical Therapy Clinic. If I refuse to sign this authorization, my medical record/ information will not be released. If this is for the purposes of third-party 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 one 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.

Client Signature:_____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness: (required for Mental Health Information releases) _____

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, (IL.Rev. Stat., ch. 91 ½, par. 801 et seq.) you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.