

The Center for Health and Counseling Services Lewis University, Mother Teresa Hall One University Parkway Romeoville, IL 60446

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Release of Information Authorization Form

Name:	Student ID#:
Graduation Date/Last Semester Attended:	Date of Birth:
I authorize the professional staff at the Center for I University, Romeoville, Illinois to release and exch the following:	
Name of individual(s) or practice	
please provide complete address	
telephone number	fax number
The author%Immunization records	
Medical records	
Professional summary of diagnosis and treatme	ent
Other: Please describe the specific nature of in	formation to be disclosed
This authorization will expire on this date:(date is not to exceed one year)	
Purpose of Disclosure:	
Refusal to consent to disclosure or release of this	
Delay in service Limited treatment co	,
·	·
Other, specify:	
I understand that if persons or organizations I authorize information described above are not health plans, cove houses subject to federal health information privacy law which may no longer be protected by federal law. I under the informat Student Signature:	red health care providers, or health care clearing- vs, they may further disclose my health information
Witness Signature:	 Date: