



HIPAA 3

Illinois State University, Student Health Service

AUTHORIZATION (Illinois Provider)

Purpose: This form is used to authorize us to use or disclose protected health information or for another person to disclose protected health information to us for the purpose stated.

SECTION A: Psychotherapy notes.

Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information.

SECTION B: Individual authorizing use and/or disclosure.

Name, Address, Telephone, Social Security Number fields

E-mail:

SECTION C: The use and/or disclosure being authorized.

Protected Health Information to Be Use and/or Disclosed: Specifically and meaningfully describe the protected health information you are authorizing be used and/or disclosed. Check and initial if applicable:

- General Medical, Mental Health, Other (please specify), HIV/AIDS, Genetic Testing with initial lines

Entities Authorized to Use or Disclose: Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who you are authorizing to make use of and/or to disclose the protected health information described above:

Blank lines for listing entities authorized to use or disclose

Entities Authorized to Receive: Name or specifically identify the persons and/or organizations (or the classes of persons and/or organizations), including us, to whom you are authorizing the disclosure and subsequent use of the protected health information described above:

Blank lines for listing entities authorized to receive

Purpose of this Authorization:

- At request of individual, For the following purposes:

Blank lines for describing purpose of authorization

No Conditions: This authorization is voluntary. We will not condition your treatment on this authorization. If you are temporarily prohibited from completing and signing this authorization for religious reasons, you will not have to do so at this time, but will complete it as soon as you are able to do so.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. However, any mental health, substance abuse, genetic testing, or HIV/AIDS information disclosed pursuant to this authorization may not be further disclosed except pursuant to your authorization.

If you are authorizing the disclosure of psychological tests, such tests may only be disclosed to a psychologist that you have designated.

SECTION D: Expiration and revocation.

Expiration: This authorization will expire (complete one):

On ____/____/____

On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Assistant Director, Student Health Service / University Privacy Officer

Telephone: (309) 438-8658 Fax: (309) 438-5205

E-mail: Privacyofficer@ilstu.edu

Address: Campus Box 2540, Student Services Building, Normal IL 61790-2540

INDIVIDUAL'S SIGNATURE.

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

If this authorization is for mental health records, this authorization must be witnessed below.

Witness: _____

Signature: _____

Name: _____

Date: _____

I authorize ISU Student Health Service to bill my
<input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Discover
No. _____
_____ Card Verification Value Code (last 3 digits in the signature area on the back of the card).
Exp. _____ for Medical Record copy fees.
Enclosed is payment of \$ _____.
Signature _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

**Include this authorization in the individual's records.
Send copy to the Privacy Official.**

For Office Use ONLY:

Signature verified by: Witness Comparison
Recipient ID verified by: Driver's License # _____ Other

Date released: _____ Released by: _____