University of Illinois
College of Medicine at Peoria
*Department of Pediatrics*

Pediatric Diabetes Resource Center
530 NE Glen Oak
Peoria, Illinois 61603
Phone: 309-624-2480
Fax: 309-624-2481

# PARENT / SCHOOL
# AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name_____ Date of Birth _____
Last/First/Middle

Legal Guardian _____ Telephone (____)_____

I hereby authorize the Custodian of Medical Records at the University of Illinois College of Medicine in Peoria to exchange medical information in the following manner:

| | RELEASE TO: | OBTAIN FROM: |
|---|---|---|
| Person/Facility/Agency: | _____ | _____ |
| Address: | _____ | _____ |
| City, State, Zip: | _____ | _____ |

Specific description of information that may be used/disclosed:

☐ INPATIENT: Dates of Treatment: _____
☐ OUTPATIENT Dates of Treatment: _____
☐ EMERGENCY Dates of Treatment: _____
☐ Please provide complete medical record ☐ Please provide abstract of requested information
☐ OTHER: _____

The information will be used/disclosed for the following purpose:

☐ Continuing Care ☐ Personal ☐ Legal
☐ Other: _____

I authorize University of Illinois College of Medicine in Peoria to release sensitive information as indicated:

☐ AIDS/HIV ☐ DRUG/ALCOHOL ABUSE ☐ BEHAVIORAL HEALTH
☐ SEXUAL ASSULT ☐ CHILD ABUSE ☐ DEVELOPMENTAL DISABILITIES

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.

I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. However, the notification will not be valid if:

(a) Action has been taken in reliance on this authorization; or
(b) If this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

This authorization will expire on the following date, event, or condition: _____

_____

Signature: _____ Date: _____

Relationship to patient: _____ Witness: _____

We will respond to this request within 30 days of receipt of the request.

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