Wellness Center

Lake Shore Campus · Granada Center 310
6439 N. Sheridan Road · Chicago, IL 60626
P · 773.508.2530 F · 773.508.2505
W · https://www.luc.edu/wellness

Health Sciences Campus · Cuneo Center 400
2160 South First Avenue · Maywood, IL 60153
P · 708.216.2250 F · 708.216.2070

Water Tower Campus · Terry Student 250
26 E. Pearson St. · Chicago, IL 60611
P · 312.915.6360 F · 312.915.6362

Wellness Center

AUTHORIZATION TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

Patient Name (**Please Print):** _____ Date of Birth: _____
Student ID#: _____Phone #: _____

STATUS

Currently Enrolled **Graduate**_____ **Transferred**_____
Date of Graduation **Last Date of Attendance**

COPIES FOR RELEASE WILL BE AVAILABLE IN 5-7 WORKING DAYS.

Check off one: Email ___ Mail ___ Fax ___ Pick-up Lake Shore Campus ___ Pick-up Water Tower Campus ___ Pick-up Health Science Campus___

I AUTHORIZE THE WELLNESS CENTER TO RELEASE TO ( ) and/or OBTAIN FROM ( ) check all that apply:

Name: _____ Fax: _____
Address: _____ Phone: _____
Email Address:_____

THE FOLLOWING INFORMATION FROM THE ABOVE NAMED PATIENT'S RECORD

Please check off appropriate box(es). Please be as specific as possible:

- ☐ Gynecology Report(s)
- ☐ Pap Test
- ☐ Progress Report(s)
- ☐ Psychiatric or Mental Health Information
- ☐ Immunizations/TB Tests
- ☐ X-Ray Report(s)
- ☐ Physical Examination
- ☐ Developmental Disability Information HIV/AIDS
- ☐ Lab Report(s) Specify Test _____ ☐ Drug/Alcohol Information
- ☐ Other _____
- ☐ Dates of treatment/Names of treatment/tests: _____

FOR THE FOLLOWING PURPOSE(S) (Please check off appropriate boxes)

☐ Continuing Medical Care ☐ Third Party Reimbursement ☐ Other _____

NOTICE TO PATIENT

I fully understand that my medical record for the above dates may contain psychiatric/developmental disability, alcohol/drug abuse, and/or Acquired Immune Deficiency Syndrome/HIV test results and/or information. I understand that I have the right to inspect and/or obtain a copy of the information prior to use/disclosure. I understand that this Authorization is valid for 60 days from the date of signature, or until calendar date _____. I understand that if the receiver is not a health plan or health care provider the released information may be subject to redisclosure and will no longer be protected by applicable privacy laws. I understand that I may revoke this Authorization at any time by giving written notice to the Wellness Center at Loyola University of Chicago, but if I do, it will not affect any actions taken by the Wellness Center before it received the revocation. I understand that if I do not sign this Authorization, the information will not be released and/or obtained, as applicable. I am signing this Authorization voluntarily and understand that my treatment will not be conditioned upon my Authorization. I absolve Loyola University of Chicago and its agents, trustees, officers, and employees from any legal liability which may arise from the use or disclosure of this information.

_____ _____
Signature of patient or authorized legal guardian Date

_____ _____
Relationship to patient, if signed by authorized representative Date

_____ _____
Witness Date

_____ _____
Signature of staff member who received form at LUCWC Date

For Office Use Only

Date Emailed/Mailed/Faxed_____ Date of Pick-Up_____