# Southern Illinois University at Edwardsville

## Authorization for the Use, Disclosure, and Receipt of Protected Health Information

**I, _____, request and authorize my Health Provider**:

Name: _____ Specialty: _____

Address: _____ City/State/Zip: _____

**to release my medical information to the SIUE Medical Leave of Absence Review Team (as appropriate) for the purpose of a Medical Leave of Absence review. Please upload this completed application when submitting your Request for Medical Leave of Absence Form.**

### Records Authorized to be Obtained

**Date Range and Specific Medical Records Requested**: _____/ _____/ _____ to _____/ _____/ _____
(Note: The date range should be relevant to the Semester in question but may need to include relevant information just prior to the semester or immediately following).

### Please Check all items you will be submitting to support your case:

_____ **ALL** Medical, Psychiatric, Counseling, or Psychological records including alcohol/drug abuse, addiction records, STD/ HIV information within the date range noted above.

_____ General Medical Records (including all office visit notes, diagnostic tests, consultations, counseling and HIV information/test results).

_____ Mental Health Records only (Psychologist/Mental Health Counselor or Primary Care Clinician) *

_____ Psychiatry Clinic Records only* _____ Specific Evaluation or Consultation Report and date: _____

_____ Other _____

### Purpose of Disclosure:

The SIUE Medical Leave of Absence Review Team consists of a representative from Student Affairs, Health Services, Counseling Services, and the Provost Office. The team's primary responsibility is to review and approve medical leave of absence requests as well as requests to return to the university after a leave of absence. The review process entails a thorough examination of the student's medical documentation, with the team heavily relying on information provided by the student's treatment provider. In cases where further clarification is necessary, a team representative may contact the provider. The team conducts the review process in a timely and individualized manner, ensuring that all relevant factors are taken into account.

**I understand** that the information in my records may include information relating to: Alcohol/Drug Abuse, STI/STDS, HIV/AIDS, Behavioral and/or Genetics.

**I understand** that a summary of the Mental Health records may be provided in lieu of complete Psychiatric records at the discretion of the Clinician.

**I understand** that once information is disclosed, the information is subject to redisclosure and may no longer be protected by federal privacy regulations.

I understand that I have a right to revoke this authorization at any time except in the case that action has already been taken regarding the request for authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the SIUE Medical Leave of Absence Review Team. I understand that the revocation will not apply to my health plan when the law provides my plan with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire in six (6) months from the date signed below**.

**Expiration Date**: _____ **(If left blank, authorization will expire six (6) months)**

Name: _____ Birth date: _____/ _____/ _____ Phone: (_____) _____-_____

Address: _____

This release will be valid for _____ from the date of my signature.

Signature of Student or *Legal Representative _____ Date: _____

Relationship: _____ Date: _____

*** Note: Please attach a copy of the Power of Attorney if required.**