Governors State UNIVERSITY

Registrar's Office
1 University Parkway
University Park, IL 60484
708.235.2145
Fax: 708.534.1640
www.govst.edu/immunizations

Authorization for Disclosure of Confidential Healthcare Information

Name: _____

Date of Birth: _____ GSU Student ID number: _____

Phone number: _____ Date of request: _____

☐ **I authorize the Governors State University medical records technician to release/receive (circle one) information from my immunization records as described below:**

Agency/University/College/Person: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

SPECIFIC RECORDS TO BE DISCLOSED:

☐ Immunization documents ☐ Other (please describe): _____

PURPOSE OF DISCLOSURE:

☐ State immunization requirements ☐ Other: (please describe) _____
Illinois College Immunization Act (110-ILCS 20)

BY CHECKING THE BOXES BELOW, I DEMONSTRATE THAT I UNDERSTAND THE FOLLOWING:

☐ I have the right to revoke this consent at any time.
☐ I have the right to inspect and receive copies of information to be disclosed.
☐ Revoking this consent will have no effect on disclosures made before the revocation of consent.
☐ Any revocation of consent must be submitted in writing to the GSU Medical Records Technician and signed by the person who gave the consent.
☐ This authorization expires 90 calendar days after it is signed or upon the following specific date, event, or condition:

Signature of consenting individual: _____ Date: _____

Name of witness: _____

Signature of witness: _____ Date: _____

FOR OFFICE USE ONLY

☐ Mail ☐ Pick-up date: _____ ☐ Fax to: _____

pages: _____ Date: _____

03/2018