Student Health and Wellness Center
Illinois Institute of Technology
10 W 35th Street 3rd Fl.
312.567.7550
fax 312.567.5702

Permission to Receive/Disclose Confidential Information

I, (name) _____ (student ID #) _____

authorize the Student Health and Wellness Center at Illinois Institute of Technology (IIT) to receive and/or disclose the information about me from/to:

_____

_____

The information to be exchanged includes:

- ☐ Attendance history for counseling
- ☐ Summary of counseling information or information disclosed in counseling
- ☐ Complete counseling record
- ☐ Assessment/Test records and reports
- ☐ Medical records or medical information
- ☐ Other information as specified:
  _____

I understand that I have the right to inspect and copy the information disclosed.

It has been explained to me that if I refuse to consent to release this information, the following are the consequences:

_____

This consent is valid from the signature date of this document through: ___/___/___ (allow at least one month). I understand that I may revoke this consent at any time, except to the extent that action has already been taken on it. I also understand that my records are protected under the Illinois Mental Health & Development Disabilities Act and/or the Illinois Alcoholism & Other Drug Abuse and Dependency Act. Also, my records may be protected under certain federal laws and regulations. I understand that my records cannot be disclosed without my written consent unless otherwise provided for in the relevant laws and regulations.

Client's Signature Date

Parent/Guardian Signature (if needed) Date

Witness Date

Under the provisions of the Illinois Mental Health and Developmental Disabilities Act (IL Rev. Stat., ch. 91 ½, par. 801 et.seq.), you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to said redisclosure.