Illinois Institute of Technology Student Health & Wellness Center
IIT Tower, Suite 3D9-1 - 10 W 35th St, Chicago, IL 60616 - Phone: 312.567.7550 Fax: 312.567.5702
Email: student.health@iit.edu

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

STUDENT INFORMATION (Please include a picture ID with your request):

Name: _____ DOB*(mm/dd/year)*:_____ /_____ /_____

Email:_____ CWID: _____

Phone: ( ) _____-_____ Semester of Entrance: _____/_____

Please Note: There is a charge of $5 to release your requested records. **Payment is due at the time request is made. Payment may be made online at http://web.iit.edu/shwc/services/record-release**

All records are processed within 7-14 business days. Due to confidentiality, records are not released via e-mail.

I APPROVE THE RELEASE OF MEDICAL RECORDS TO

Name: _____

☐ *Mail Address:_____ ☐ *Fax: ( ) _____-_____

_____ ***Please Note: * We cannot mail or fax internationally***

☐ Pick Up - You will be called when your records are available for pick up; records will only be held for ***1*** week.

Release the following Records

☐ Immunization ☐ Health ☐ Mental Health ☐ Lab Results ☐ Other:_____

DISCLOSURE INFORMATION

I understand that my records are protected under law and cannot be disclosed without my written permission unless otherwise provided by statues and regulations. I have the right to revoke this consent by written statement at any time prior to release. I understand that I have the right to inspect and copy the information to be disclosed although in certain instances applicable states or regulation may place restrictions on this right. No information shall be disclosed to other individuals or agencies. This consent expires at the end of every semester unless earlier revoked by me in writing.

Signature: _____Today's Date*(mm/dd/yyyy)*:____/____/_____

Witness Signature: _____ Witness Name:_____

For Office Use Only

ID Verified ___Date Rec'd: _____Payment Rec'd:__ or N/A Date Completed: _____ Time _____Initials:____ (F) (M) (P/U)