AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION AND PROTECTED MENTAL HEALTH INFORMATION

Pursuant to 740 ILCS 110/5 of the Illinois Mental Health and Developmental Disabilities Act ("MHDDA") and 45 C.F.R. § 164.508 of the Privacy Rule regulations promulgated under the Health Insurance Portability and Accountability Act ("HIPAA"), I hereby authorize the disclosure of my protected health information and/or mental health information as described below. This authorization is provided to you voluntarily and at my request.

I understand that I may not be refused treatment, payment, enrollment in a health plan or eligibility for health care benefits if I do not sign this authorization.

I further understand that once disclosed by you, the protected health information may be subject to re-disclosure by the recipient and may no longer be protected under MHDDA or HIPAA.

I am aware that I may revoke this authorization at any time by notifying you in writing, which notice of revocation will become effective immediately upon your receipt, except to the extent you have taken actions in reliance on this authorization prior to receiving notice of the revocation.

Patient/Client Name:

DOB: / /

SSN/NLU ID No.: _____

- **Purposes of the Requested Disclosures**:

  The disclosures requested pursuant to this authorization are solely for purposes of providing evaluation and counseling services to_____(Student's Name)

- **Persons/classes of persons authorized to provide information pursuant to this Authorization**:

Each and every doctor, counselor or other health care professional employed by or affiliated with _____(Medical Provider/Institution's Name) ,who examined or treated or provided counseling, evaluation or other mental health services to _____(Name of Student/Patient) for the time period _____[Start Date] through the present.

- **Persons/classes of persons authorized to receive information pursuant to this Authorization**:

  1. National Louis University, 122 S. Michigan Ave, Chicago, Ill. 60603,including and its employees and agents.

  2. Specific description of information authorized for disclosure:

  Copies of all medical and mental health records of examination and treatment rendered including but not limited to history records, chart notes and assessments, medical reports, memoranda, prescribed medication, evaluation and counseling notes, and any other records whatsoever in your possession, and testimony under oath, related to treatment, including evaluation and counselling services, rendered to_____ (Name of Student/Patient) for the dates _____(Start Date) to present.

  To comply with the Genetic Information Nondiscrimination Act of 2008 (GINA) we are asking that you not provide any genetic information of an individual or an individual's family member when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

- **This authorization shall expire on_____ (Expiration Date).**

- **A copy of this Authorization shall be considered as valid as the original**.

Dated: _____ By: _____
Name of Student/Patient

Dated: _____ By:_____
Name of Guardian, If Applicable