Southern Illinois University Carbondale
Medical Information Release

Name of Employee: _____ AIS #: _____
(please print or type)

Email Address: _____

By signing this form I hereby specifically authorize and consent to the release and disclosure by the following named medical provider or medical institution, to nursing personnel at the Student Health Center on behalf of the Human Resources Department at Southern Illinois University Carbondale, of such medical information and/or medical records concerning myself that are reasonably believed to be necessary to permit clarification of Family and Medical Leave and/or Extended Sick Leave benefits.

Name and Address of Practitioner
or Medical Institution

_____
Name

_____
Street Address

_____ _____ _____
City State Zip

Employee Signature: _____ _____
Date Signed

Witness Signature: _____ _____
Date Signed

Clear Form Print Form