

CHILDREN'S MEMORIAL HOSPITAL OF CHICAGO

JESSE BROWN VETERANS ADMINISTRATION MEDICAL CENTER

STREAMWOOD BEHAVIORAL HEALTH SYSTEMS

**AUTHORIZATION TO RELEASE SOCIAL SECURITY NUMBER AND  
DATE OF BIRTH IF APPLICABLE FOR TRAINEE REQUIREMENTS**

I, \_\_\_\_\_, hereby authorize the College of Medicine at the University of Illinois at Chicago to disclose my social security number to the staff at the following **UIC participating hospitals, Children's Memorial Hospital of Chicago, Jesse Brown Veterans Administration Medical Center and Streamwood Behavioral Health Systems**, (hereinafter "Children's Memorial Hospital of Chicago, Jesse Brown Veterans Administration Medical Center and Streamwood Behavioral Health Systems") for the purpose of facilitating the creation of an access code for me during my rotation as an UIC medical student at **Children's Memorial Hospital of Chicago, Jesse Brown Veterans Administration Medical Center and Streamwood Behavioral Health Systems**.

In giving this authorization, I knowingly and willingly waive any and all privacy and confidentiality rights to which I am entitled under Federal, State or Local law or under University rules, regulations, statutes or policies related to the subject information.

I further agree to hold the Board of Trustees of the University of Illinois, its officers, employees, representatives, agents and assigns free and harmless of and from any and all lawsuits or causes of action which may arise as a result of this authorization.

\_\_\_\_\_  
Printed Name

M1- M2- M3 – M4 (circle one)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date