State of Illinois
Department of Human Services - Division of Rehabilitation Services

AUTHORIZATION TO USE/DISCLOSE MEDICAL AND CONFIDENTIAL INFORMATION

Customer Name:

Last: ______ First: ______ Middle: ______

Previous name (if any): ______

Street Address: ______ Date of Birth: ______

City: ______ Sex: ☐ Male ☐ Female

State: ______ Zip: ______ RIN, if issued: ______

Phone: ______

This authorization will allow IDHS to: (Check one)

obtain information from, ☐ exchange information with: ☐ provide information to, ☐

Name of Person/Agency: ______

Address of Person/Agency: ______

Telephone: ______ Fax: ______

Information is to be obtained by the Illinois Department of Human Services, send it to:

Telephone: ______ Fax: ______ Telephone TTY: ______

Information Needed: Customer must initial each category with an "*" preceding it.

☐ * Medical History ______
☐ * Diagnosis/Prognosis ______
☐ * Social History ______
☐ * Psychiatric History ______
☐ * Psychiatric Evaluations ______
☐ * Current Medications ______
☐ * Psychological History ______
☐ * Psychological Reports ______
☐ * Treatment/Habilitation Plans ______
☐ * Treatment/Habilitation Progress Notes ______

☐ Academic Performance Records
☐ Achievement Testing
☐ School Transcript
☐ Individualized Education Plan (IEP)
☐ * Alcohol/Substance Abuse Records ______
☐ Legal History
☐ Employment History
☐ Financial History
☐ * HIV/AIDS Test Results ______
☐ * Genetic Testing Record ______
☐ * STD Testing Records ______

* DRS Case File Information ______

☐ Bureau of Blind Services
☐ Bureau of Field Services
☐ * Other request as specified: ______
☐ Bureau of Home Services

Specify other information requested:

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Information initialed above to include dates of service or treatment from calendar dates:

__________________________ to __________________________ .

Reason for the Authorization: (Check all that apply)

- ☐ Determine Eligibility
- ☐ Provide for Services
- ☐ Refer for Services
- ☐ Pay for Services
- ☐ Allow for Audit or Program Evaluation
- ☐ Provide Case Coordination/Management
- ☐ Allow for Review for Appeal
- ☐ Customer has Requested it
- ☐ Other Request as Specified Below:

____

____

____

Check only one box below:

☐ If the purpose of this release is to receive services or treatment, refusal to sign this release will result in the following consequences: Information will not be disclosed or obtained.

☐ If the purpose of this release is to determine eligibility, refusal to sign the release will result in the information not being released and may affect this agency's ability to determine eligibility for services.

Signing this authorization is voluntary. I have a right to look at or copy the information being released. I understand that the information released will not be used for marketing without my express permission. I have the right to revoke this authorization by filling out the revocation section at the bottom of this document and returning it to this agency. I realize that once the agency receives my revocation, no more information will be released, used or exchanged. However, I also understand that any information released, used or exchanged prior to the agency receiving my revocation cannot be retrieved.

Restriction on redisclosure: Because Illinois and federal laws are more restrictive than HIPPA, anyone who receives this information cannot give it to anyone else without my express permission.

This information includes: mental health or developmental disabilities records; HIV/AIDS/STD and genetic testing records; alcohol and substance abuse records; school and Early Intervention records; WIC; public assistance program records; financial records; legal records; and records of service provided through the Illinois Department of Human Services' Division of Rehabilitation Services.

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(Controlling statutes and regulations include: The Mental Health and Developmental Disabilities Confidentiality Act; AIDS Confidentiality Act; Family Educational Rights and Privacy Act; the Social Security Act; Confidentiality of Alcohol and Drug Abuse Patient Records Regulation; the Public Aid Code; and other federal laws covering SNAP, Temporary Assistance for Needy Families,
and Medicaid.)

This authorization is valid until this calendar date: Month ______ Day ________ Year ________

Customer Signature: ________________________________ Date: ______________

Parent/Guardian Name: ________________________________

Parent/Guardian Signature: ________________________________ Date: ______________

Personal Representative Name: (if applicable): ________________________________

Personal Representative Signature: (if applicable): ________________________________ Date: ______________

Witness Name:(if applicable): ________________________________

Witness Signature:(If applicable): ________________________________ Date: ______________

REVOCATION SECTION:

I no longer want my medical or confidential information shared with:

____

____

Customer Signature: ________________________________ Date: ______________

Witness Signature:(If applicable) ________________________________ Date: ______________

Other Name: ________________________________

Other Signature: ________________________________ Date: ______________

Relationship to Customer: ________________________________