



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: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ RIN, if issued: \_\_\_\_\_ Sex: Male: \_\_\_\_\_ Female: \_\_\_\_\_

This authorization will allow DHS to: (Check one) \_\_\_\_\_ obtain information from, \_\_\_\_\_ provide information to, \_\_\_\_\_ exchange information with:

Name of Person/Agency: \_\_\_\_\_

Address of Person/Agency: \_\_\_\_\_

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

**Tazewell-Mason Counties Special Education Association, 300 Cedar Street, Pekin, IL 61554**

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

- |   |   |
|---|---|
| <input checked="" type="checkbox"/> * Medical History _____             | <input type="checkbox"/> Academic Performance Records                   |
| <input type="checkbox"/> * Diagnosis/Prognosis _____                    | <input type="checkbox"/> Achievement Testing                            |
| <input checked="" type="checkbox"/> * Social History _____              | <input type="checkbox"/> School Transcript                              |
| <input type="checkbox"/> * Psychiatric History _____                    | <input checked="" type="checkbox"/> Individualized Education Plan (IEP) |
| <input type="checkbox"/> * Psychiatric Evaluations _____                | <input type="checkbox"/> * Alcohol/Substance Abuse Records _____        |
| <input checked="" type="checkbox"/> * Current Medications _____         | <input type="checkbox"/> Legal History                                  |
| <input checked="" type="checkbox"/> * Psychological History _____       | <input checked="" type="checkbox"/> Employment History                  |
| <input checked="" type="checkbox"/> * Psychological Reports _____       | <input type="checkbox"/> Financial History                              |
| <input type="checkbox"/> * Treatment/Habilitation Plans _____           | <input type="checkbox"/> * HIV/AIDS Test Results _____                  |
| <input type="checkbox"/> * Treatment/Habilitation Progress Notes _____  | <input type="checkbox"/> * Genetic Testing Record _____                 |
| <input type="checkbox"/> * DRS Case File Information _____              | <input type="checkbox"/> * STD Testing Records _____                    |
| <input type="checkbox"/> Bureau of Blind Services                       |   |
| <input checked="" type="checkbox"/> Bureau of Field Services            |   |
| <input type="checkbox"/> Bureau of Home Services                        |   |
| <input checked="" type="checkbox"/> * Other request as specified: _____ |   |



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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)

<input checked="" type="checkbox"/> Determine Eligibility	<input type="checkbox"/> Provide for Services
<input checked="" type="checkbox"/> Refer for Services	<input type="checkbox"/> Pay for Services
<input type="checkbox"/> Allow for Audit or Program Evaluation	<input type="checkbox"/> Provide Case Coordination/Management
<input type="checkbox"/> Allow for Review for Appeal	<input type="checkbox"/> Customer has Requested it
<input type="checkbox"/> Other Request as Specified Below:	

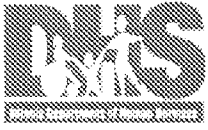
Check only one box below:

- 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 HIPAA, 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 Food Stamps, Temporary Assistance for Needy Families, and Medicaid.)

This authorization is valid until this calendar date: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_  
 (Dates must not be longer than one calendar year.)

Customer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative Signature:  
 (If applicable) \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (If applicable)

REVOCACTION SECTION:

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

\_\_\_\_\_  
 \_\_\_\_\_

Customer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (If applicable)

Other Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Customer: \_\_\_\_\_