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 DHS to:(Check one)

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

Name of Person/Agency: _____

Address of Person/Agency: _____

Voice Phone: _____ Fax Phone: _____

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

TMCSEA, 300 Cedar Street, Pekin, IL 61554

Voice Phone: 309/347-3532 Fax Phone: 309/346-0440 TTY Phone: 800-526-0857 or 7-1-1

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

- ☑ * Medical History ____ Freshman physical
- ☐ * 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 Records ____
- ☐ * STD Testing Records ____

* DRS Case File Information ____

☑ Bureau of Field Services ☐ Bureau of Home Services ☐ Bureau of Blind Services

☑ * Other request as specified: ____

Physical Therapy, Occupational Therapy, Speech/Language, Mental Health, and Psychiatric Reports

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

Reason for the Authorization: (Check all that apply)

- [x] Determine Eligibility
- [ ] Refer for Services
- [ ] Allow for Audit or Program Evaluation
- [ ] Allow for Review for Appeal
- [x] Other Request as Specified Below:

STEP - Secondary Transitional Experience Program

- [x] Provide for Services
- [ ] Pay for Services
- [ ] Provide Case Coordination/Management
- [ ] Customer has Requested it

Check only one box below:

- [x] 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 (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 Signature: _____ Date: _____

Relationship to Customer: _____