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: ______________________________

City: _________________________

State: ___ Zip: __________

Phone: ________________

Date of Birth: ___________

Sex: Male: __ Female: __

RIN, if issued: __________

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:

____

Voice Phone: _______________ Fax Phone: _______________ TTY Phone: _______________

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 Records ____
- ☐ * STD Testing Records ____

* DRS Case File Information ____

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

☐ * Other request as specified: ____

____
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____
____
____

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

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 (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: ______________________________