DuPage County Health Department

Authorization to Release and Disclose Client Information

Client Identification

Full Name: _____

Date of Birth: _____ Phone #: _____

Address: _____

City State Zip

Release Records To

(Where do you want the information sent? ***Who*** may have the information?)

Name: _____ Attention: _____

Address: _____

City State Zip

Phone Number: _____ Fax Number: _____

Get Records From

(Who has the information you want released?)

Name: _____

Address: _____

City State Zip

Information Requested

(What documents do you want sent or released?)

Date(s) of Treatment From: _____ to _____ or a specific date: _____

BEHAVIORAL HEALTH RECORDS: ☐ Abstract * (see instruction page for definition)

☐ Discharge Summary ☐ Mental Health Assessment ☐ Treatment Plans & Reviews ☐ Psychiatric Evaluation

☐ Psychiatric Progress Notes ☐Medication List ☐ Lab Results/Reports ☐ Progress Notes

COMMUNITY HEALTH RECORDS:

☐ Lab Results/Reports ☐ Immunization Record ☐ Dental Records (Notes & X-Rays) ☐ Visit Note ☐ HIV/AIDS

OTHER:

☐ Billing Information ☐ Other: _____

Purpose of Release

(Why is it needed?)

☐ Continuity of Care ☐Transfer of Care ☐ Personal Use/Review

☐Treatment ☐ Social Security Appeal/Disability Determination ☐Emergency Contact Only

☐ Other: _____

Release Instructions

(How do you want the information and ***How*** should we get it to you?)

Release Method/Format Requested: (Check One)

☐Paper ☐CD ☐Verbal ☐Fax #:_____

Delivery Preference:

☐ Pick Up ☐Mail to Address Noted Above. If different: _____

*Please allow 30 days for processing.

SUBMIT

Verify that all sections are completed in full, sign and date. Upon completion, please do one of the following:

☐ Mail the form to: Medical Records, 111 N. County Farm Rd, Wheaton, IL 60187

☐ Fax the form to: Medical Records 630-510-5485

☐ Drop off at your nearest Health Department location

- A fee may be charged for the cost of processing this request.
- This authorization will automatically expire one year from the date of signature unless a different date is noted: _____/_____/_____
- This authorization may be revoked in writing at any time. Revocation will not apply to information that has already been released.
- You have the right to inspect and copy the information to be disclosed.
- I also understand that information in my health record which may be related to behavioral health, sexually transmitted infection/disease, AIDS or HIV, domestic violence, alcohol or drug use, and/or genetic testing will not be disclosed without my specific consent.
- My providers will use secure methods that meet the privacy and security standards of both the Health Insurance Portability and Accountability Act (HIPAA) and Illinois law, to exchange my health information.
- Re-disclosure of information is prohibited unless the person who consented to the disclosure specifically consents to re-disclosure.
- DuPage County Health Department will not restrict treatment if you choose not to sign this authorization. I understand it may result in a delay of service, limited treatment coordination, inability to release information and/or limited continuity of care.

Signatures

Your signature indicates that you have read and understand the form and authorize release of your information as described above.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

(Clients 12 to 17 years of age must sign in addition to the Parent or legal representative) (If signed by legal representative, indicate the relationship to the client or authority to act for client)