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: ___________________ ☐ Evaluation ☐ Psychosocial History ☐ Treatment Recommendations ☐ Discharge Summary ☐ Treatment Plan ☐ Treatment Progress/PAIP Progress ☐ Health History ☐ Substance Use/Abuse History ☐ Physical/Lab Exam Results ☐Urine Screen Results **OTHER:** ☐ Billing Information ☐ Other: ______________________________
Purpose of Release ***(Why** is it needed?)*	☐ Coordination of Services ☐Transfer of Care ☐ Personal Use/Review ☐ Treatment ☐ Court Testimony ☐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 Forensic Behavioral Health Services: 505 N. County Farm Road, Wheaton, IL 60187

- 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.
- 42 CFR Part 2 Prohibits unauthorized disclosure of these records.
- Re-disclosure of this information is prohibited.

Signatures *Your signature indicates that you are not impaired, have read and understand the form and authorize release of your information as described above.*	Client Signature: ______________________________ Date: __________________ Guardian Signature: ______________________________ Date: __________________ Witness Signature: ______________________________ Date: __________________ *If signed by legal representative, indicate the relationship to the client or authority to act for client.*