

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 <i>(Where do you want the information sent? Who may have the information?)</i>	Name: _____ Attention: _____ Address: _____ City State Zip Phone Number: _____ Fax Number: _____
Get Records From <i>(Who has the information you want released?)</i>	Name: _____ Address: _____ City State Zip
Information Requested <i>(What documents do you want sent or released?)</i>	Date(s) of Treatment From: _____ to _____ or a specific date: _____ BEHAVIORAL HEALTH RECORDS: <input type="checkbox"/> Abstract * (see instruction page for definition) <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Mental Health Assessment <input type="checkbox"/> Treatment Plans & Reviews <input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> Psychiatric Progress Notes <input type="checkbox"/> Medication List <input type="checkbox"/> Lab Results/Reports <input type="checkbox"/> Progress Notes COMMUNITY HEALTH RECORDS: <input type="checkbox"/> Lab Results/Reports <input type="checkbox"/> Immunization Record <input type="checkbox"/> Dental Records (Notes & X-Rays) <input type="checkbox"/> Visit Note <input type="checkbox"/> HIV/AIDS OTHER: <input type="checkbox"/> Billing Information <input type="checkbox"/> Other: _____
Purpose of Release <i>(Why is it needed?)</i>	<input type="checkbox"/> Continuity of Care <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Personal Use/Review <input type="checkbox"/> Treatment <input type="checkbox"/> Social Security Appeal/Disability Determination <input type="checkbox"/> Emergency Contact Only <input type="checkbox"/> Other: _____
Release Instructions <i>(How do you want the information and How should we get it to you?)</i>	Release Method/Format Requested: (Check One) <input type="checkbox"/> Paper <input type="checkbox"/> CD <input type="checkbox"/> Verbal <input type="checkbox"/> Fax #: _____ Delivery Preference: <input type="checkbox"/> Pick Up <input type="checkbox"/> 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: <input type="checkbox"/> Mail the form to: Medical Records, 111 N. County Farm Rd, Wheaton, IL 60187 <input type="checkbox"/> Fax the form to: Medical Records 630-510-5485 <input type="checkbox"/> Drop off at your nearest Health Department location
<ul style="list-style-type: none"> • 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 <i>Your signature indicates that you have read and understand the form and authorize release of your information as described above.</i>	Client Signature: _____ Date: _____ Parent/Guardian Signature: _____ Date: _____ Witness Signature: _____ Date: _____ <i>(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)</i>