

Options & Advocacy for McHenry County
365 Millennium Drive - Suite A
Crystal Lake, IL 60012

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION (DISABILITY RELATED ASSESSMENT SERVICES)

By signing this Authorization, I authorize the use or disclosure of my individually-identifiable health information maintained by:

Options and Advocacy for McHenry County
Print Name Organization Providing Information

365 Millennium Drive Suite - A Crystal Lake, IL 60012
Print Address Organization Providing Information

My health information may be disclosed under this Authorization to:

Print Name of Recipient

Print Address of Recipient

This consent valid until _____

For the Purpose of: Service Coordination and Advocacy

Health information includes information collected from me or created by the Provider, or information received by the Provider from another health care provider, school or residential program. Health information may relate to my past, present or future physical or mental health or condition, and the provision of my health care.

SECTION B: SCOPE OF USE OR DISCLOSURE:

Health information that may be used or disclosed through this Authorization is as follows:

- Specific health information including: Personal, Medical, Financial, Psychological, Psychiatric, Vocational, Behavioral, Educational, ICAP, Service Plan: Testing, Reports, Evaluations and Assessments

- All health information about me pertaining to my identity and services that may be recommended through Options & Advocacy excluding the following:

SECTION C: OTHER IMPORTANT INFORMATION

1. I understand that the Provider cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information.
2. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain services from Options & Advocacy.

3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that I must provide any notice of revocation in writing to the Privacy Officer of Options & Advocacy, 365 Millennium Dr., Suite A, Crystal Lake, IL 60012.

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client's signature: _____ Date of signature: _____

Print client's full name: _____

Client's Home
Address: _____

Client's Social Security Number: _____ Date of Birth: _____

When a client is not competent to give consent, the signature of a parent, guardian, health care agency (proxy) or other representative is required.

Signature of legal representative: _____ Date of signature: _____

Print name: _____

Relationship of representative to client: _____

Witness _____ Date _____

The client will be provided with a copy of the signed authorization.

NOTE TO RECEIVING AGENCY/PERSON: Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.

WORD/HIPAA/Authorization Form. Doc 01-03