HIPAA Release Form Illinois

SECTION A: INDIVIDUAL FOR WHOM MEDICAL RECORDS ARE BEING REQUESTED

First Name: _____ Middle Name: _____

Last Name: _____ Previous Name (if applicable): _____

Street Address: _____ Date of Birth: _____ dd / mm / yyyy

City/State/Zip: _____ Daytime telephone number: _____

SECTION B: PERSON OR ORGANIZATION FROM WHOM MEDICAL RECORDS ARE REQUESTED

Hospital/agency/clinic/physician: _____ Attention: _____

Address: _____ Phone: _____

Fax: _____

SECTION C: SEND REQUESTED MEDICAL INFORMATION TO

Illinois Department of Human Services

FCRC: _____ Attention: _____

Address: _____ Phone: _____

Fax: _____ TTY: _____

SECTION D: INFORMATION TO BE DISCLOSED FROM DATE (OR RANGE OF DATES)

Date: _____ dd / mm / yyyy Date: _____ dd / mm / yyyy

Check information needed

- ☐ History and Physical
- ☐ Emergency Department Record
- ☐ Alcohol/substance Abuse
- ☐ Progress Notes
- ☐ Social History
- ☐ Consultation Reports
- ☐ Psychiatric Outpatient Notes (pre/post hospitalization)
- ☐ Behavior Plans
- ☐ Physician's Discharge Summary
- ☐ Diagnostic Test Reports
- ☐ Pathology Reports
- ☐ Rehab Records
- ☐ HIV/AIDS
- ☐ Psychiatric Evaluation
- ☐ Developmental Disabilities Records
- ☐ Mental Health Record

Other:

SECTION E: EXPIRATION OF AUTHORIZATION

This authorization is valid until the calendar date: (Month/Day/Year): dd / mm / yyyy

Unless an earlier date is specified, this authorization will expire 12 months from the date of signature below.

SECTION F: SIGNATURE

Signature of Individual:
Date: _____ dd / mm / yyyy

Signature of Representative:
Date: _____ dd / mm / yyyy

Authority to represent individual:

◯ Parent ◯ Guardian ◯ Power of Attorney ◯ Authorized Representative

Signature of Witness (or 2nd parent/guardian):
Date: _____ dd / mm / yyyy

SECTION G: REVOCATION SECTION. (IF COMPLETED, SEND COPY OF ENTIRE FORM TO PERSON OR ORGANIZATION NAMED IN SECTION B).

☐ I no longer want health information pertaining to the person named in Section A shared with the Department of Human Services.

☐ I understand action already taken before the revocation is received is not affected

Signature of Individual or authorized representative:
Date: (Month/Day/Year): _____ dd / mm / yyyy

Authority to represent individual:

◯ Parent ◯ Guardian ◯ Power of Attorney ◯ Authorized Representative