JCFS Chicago

Consent For Release of Protected Health Information

Client(s) Name_____ Birthdate(s) _____

Having been fully informed of the policies and procedures of JCFS Chicago (JCFS) regarding the authorization and/or request for release of information as stated, I/we hereby authorize JCFS Chicago to:

☐ Release to ☐ Obtain from ■ Both Release to and Obtain from

_____ _____ _____

facility/person Street address phone number

_____

City State Zip

the information that is checked ☑ below:

■ 1. Diagnosis and treatment information: _____

_____

■ 2. Medical information (current physical, current dental, immunization records, additional information as specified): _____

_____

■ 3. Psychiatric/Psychological /Therapist reports (specify): _____

_____

■ 4. Education (transcripts, Multidisciplinary Conference report, Individual Educational Plan, educational testing, academic and behavioral reports, additional information as specified): _____

_____

■ 5. Social History/Assessment:_____

_____

*☐ 6. HIV/AIDS-related information: _____

_____

*☐ 7. Genetic testing information:_____

_____

*☐ 8. Alcohol and/or any Substance Abuse Patient Information: _____

_____

Client(s) Name_____ Birthdate(s)_____

This information is disclosed from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

☐ 9. Other: _____

THE PURPOSE FOR REQUESTING THIS INFORMATION:

■ Treatment Planning & Treatment	■ Coordination of Services	☐ Payment
■ Pre-Admission Evaluation	☐ Other	☐ Health Care Operations

I/We understand that, if the persons or organizations I/we authorize below to receive and/or use the protected health information subject to this authorization are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. **However, any mental health, alcohol and substance abuse, genetic testing or HIV/AIDS information disclosed pursuant to this authorization may not be redisclosed except pursuant to my/our authorization.**

I/We authorize information to be transmitted by

■ Fax ■ Mail ■ E-mail ■ Verbal Disclosure ■ Web-based System

I/We request the following restrictions to the use or disclosure of my/our protected health information:

_____

_____

It is understood that the person authorizing release of this information has the right to inspect and copy the information to be disclosed and that this information will not be redisclosed in compliance with Illinois Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 100/5(d) (1994) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 The receiving agency may not redisclose any of this information unless the person who consented to this disclosure consents to such redisclosure.

The consequences, if any, of not signing this release are: no coordination of services

This consent is valid until_____ and may be revoked with written consent at any time
Date/Year (not to exceed one year)

except to the extent that action has already been taken.

_____ _____
(signature of client – adult or child over 12) (date)

_____ _____
(signature) (date)

_____ _____
(signature of minor 12-17 years) (date)

JCFS CHICAGO

_____ _____

(signature of parent/legal guardian) (date)

_____ _____

(signature of parent/legal guardian) (date)

Witnessed by: _____ _____

(signature of witness) (date)

***Supervisory review and signature is required when any of the following information is obtained and/or released using this form:**

- **Alcohol and/or Substance Abuse Patient Information**
- **HIV/AIDS related medical information**
- **Genetic Testing Information**

Supervisor: _____ **Date/Year:** _____

Revocation of the above authorization

I/We, _____ revoke authorization for release of protected health information described above.

Client name

Signed: _____ _____

Parent or Guardian Date/Year

Signed: _____ _____

Parent or Guardian Date/Year

Signed: _____ _____

Signature of person 12 years or older Date/Year

Signed: _____ _____

JCFS Clinician/Employee signature Date/Year

Signed: _____ _____

Witness Date/Year

Distribution: original to be placed in record
copy to client
copy sent

JCFS Chicago

Consent For Release of Protected Health Information

PURPOSE OF FORM

The Consent for Release of Information form is a consent form used to obtain or release client information (specified on the form) to or from other agencies or individuals. This form is often employed during the intake process in the various programs of the agency. This form **MUST BE** signed by the client aged 12 or over.

FOR USE IN THE FOLLOWING PROGRAMS (Program Description Name)

All programs

SPECIAL INSTRUCTIONS

Please specify the client information released/obtained by checking the appropriate box(es) and then write in specific information requested or disclosed.
NOTE: If any of the following information is obtained and/or released using this form, supervisory review and signature is required: Each contact/request requires a separate consent.

- **Alcohol and/or Drug Abuse Patient Information**
- **HIV/AIDS related medical information**
- **Genetic Testing Information**

RENEWAL PROCEDURES

Consent is valid until the date written on the form, and can be revoked with written consent at any time.