DUPAGE COUNTY HEALTH DEPARTMENT

Authorization to Release and Exchange Health Information

Client Name:	Client Date of Birth:
Street Address:	Telephone Number:
City, State, Zip:	Fax Number:

I understand that by signing this form, I agree to allow the providers involved in my healthcare to communicate with each other about my care and share my health information for the following purposes: **(Check all that apply)**

☐ Treatment ☐ Care coordination ☐ Care continuity ☑ Other, specify LEGAL.

I hereby authorize the following providers or individuals to release and exchange written, oral or electronically submitted information, on the individual client named above:

Provider/Organization/Individual Who May Disclose and Receive: ☐ **AMITA** ☐ **Self**	
Or specify and complete additional information below ☑ **Other** RECORDS DEPOSITION SERVICE, INC.	
Street address: 120 W. MADISON ST., SUITE 300	
City, State, Zip Code: CHICAGO, IL 60602	
Telephone Number: 312-553-8900	**Fax Number:** 312-553-8901

Expiration: This authorization expires one year from the date signed below, or on *(insert exact date)*: _____, whichever is sooner.

Information to be Disclosed: Treatment Date(s): _____ to _____		
Behavioral Health*	**Public Health**	**General and Other**
☐ Mental Health Assessment	☐ Provider Chart Note(s)	☐ Lab Reports
☐ Psychiatric Evaluation	☐ Dental Records	☐ Financial and/or Billing
☐ Medication Information	☐ Treatment Plans/Reviews	☐ Immunizations
☐ Psychiatric Progress Notes	☐ Health/Social History	☑ Other, Please Specify: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST
☐ Treatment Plans/Reviews	☐ HIV/AIDS Related Information/Records*	
☐ Discharge Summary/Closing	☐ STI/STD Related Information or Records*	

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. I understand my treatment, payment, or eligibility for benefits will not be affected whether or not I sign the form. I also understand that if I choose not to sign this form my health information will not be disclosed/obtained. I further understand that refusal to consent to disclosure or release of information may result in a delay of service, limited treatment coordination and/or limited continuity of care.

I understand that authorizing the use or disclosure of the information identified above is voluntary and I am not required to sign this form in order to receive healthcare services. I understand that I have a right to inspect and copy my health information. *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.

I understand that I may revoke this authorization in writing at any time; and, revocation will not apply to information that has already been released in response to this authorization. I also understand that re-disclosure of information is prohibited unless the person who consented to the disclosure specifically consents to re-disclosure.

_____ _____

Signature of Client **Date**

(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)

_____ _____

Signature of Parent or Legal Representative **Date**

_____

Parent or Legal Representative Relationship to Client

_____ _____

Witness signature **Date**

To Be Completed By Office Only

_____ (initial) Client has received a copy of this signed Authorization to Release and Exchange Health Information.

Client ID: _____ 9/2016