



**AUTHORIZATION TO RELEASE  
HEALTH INFORMATION**

**DIVISION OF SPECIALIZED CARE  
FOR CHILDREN**

**Child's Name:** \_\_\_\_\_  
(Last) (First) (Middle) (DSCC Number) (Birthdate)

\_\_\_\_\_  
(Last) (First) (Middle) (Parent/Guardian) (Last) (First) (Middle)

**I hereby authorize DSCC to:**

**Release to:**

**Obtain from:**

Agency/Provider Name: \_\_\_\_\_

Agency/Provider Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Specific description of information that may be used/disclosed:**

Medical/clinic reports \_\_\_\_\_  
Date(s) of Service

Social service information \_\_\_\_\_  
Date(s) of Service

Speech/lang./aud. reports \_\_\_\_\_  
Date(s) of Service

Other \_\_\_\_\_  
Date(s) of Service

**Note: Information not specifically listed above will not be disclosed.**

This information will be used/disclosed for the following purpose(s):

- a.  Care-Coordination/Case-Management
- b.  Establishing medical eligibility

- c.  Determining DSCC payment for care
- d. \_\_\_\_\_

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment or receive payment, but may affect my eligibility for benefits. I have the right to inspect and request a copy of the information to be disclosed. I understand that my refusal to consent to disclosure or my withdrawal of consent will have the following consequences, if any: \_\_\_\_\_

**I authorize DSCC to re-release sensitive information as indicated:**

- |                                         |                                             |                                                     |
|-----------------------------------------|---------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> AIDS/HIV       | <input type="checkbox"/> DRUG/ALCOHOL ABUSE | <input type="checkbox"/> BEHAVIORAL HEALTH          |
| <input type="checkbox"/> SEXUAL ASSAULT | <input type="checkbox"/> CHILD ABUSE        | <input type="checkbox"/> DEVELOPMENTAL DISABILITIES |

I understand that I may withdraw this authorization at any time by written notice unless DSCC has already acted in reliance of this notice.

**I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.**

This authorization will expire on the following date, event, or conditions: \_\_\_\_\_

Signature: \_\_\_\_\_  
Child Date

\_\_\_\_\_  
Parent/Guardian Date

\_\_\_\_\_  
Relationship to child

\_\_\_\_\_  
Witness Relationship to child

**We are required to respond to this request within thirty (30) days of receipt of the request.**

**NOTICE TO RECEIVING AGENCY/PERSON:**

**Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, you may not disclose any information covered by that Act unless the person who consented to this disclosure specifically consents to such disclosure.**

**SEND INFORMATION TO:**