SPECIALIZED CARE FOR CHILDREN

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Child's Name: _____ _____ _____ _____ _____
(Last) (First) (Middle) (DSCC Number) (Birthdate)

Applying Parent/Guardian: _____ _____
(Last) (First)

Other Parent/Guardian: _____ _____
(Last) (First)

I hereby authorize Specialized Care for Children to release to/obtain from:

Agency/Provider Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Specific description of information that may be used/disclosed:

☐ Medical/clinic reports
☐ Speech/lang./aud. Reports
☐ OT/PT
☐ Social service information
☐ Other: _____

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 Specialized Care for Children payment for care
d. ☐ Other: _____

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: inability or difficulty providing and/or paying for medical care.

I authorize Specialized Care for Children to re-release sensitive information as indicated:

☐ AIDS/HIV ☐ Drug/Alcohol Abuse ☐ Behavioral Health ☐ Genetic Information
☐ Sexual Assault ☐ Child Abuse ☐ Developmental Disabilities

I understand that I may withdraw this authorization at any time by written notice unless Specialized Care for Children 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: _____

Signature: _____ _____ _____
Authorizing Child/Parent/Guardian Date 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 redisclose any information covered by that Act unless the person who consented to this disclosure specifically consents to such redisclosure.

SEND INFORMATION TO YOUR LOCAL OFFICE.

UIC-SPECIALIZED CARE FOR CHILDREN

SPRINGFIELD REGIONAL OFFICE, 3135 OLD JACKSONVILLE RD., SPRINGFIELD, IL 62704-6488