SPECIALIZED CARE FOR CHILDREN

AUTHORIZATION TO RELEASE HEALTH INFORMATION

DSCC# _____

Participant's Name: _____ (Last) _____ (First) _____ (Middle) _____ (Birthdate)

Legally Responsible Adult: _____ (Last) _____ (First) Relationship: _____

Legally Responsible Adult: _____ (Last) _____ (First) Relationship: _____

DISCLOSURE AUTHORIZATION

I authorize the employees, contractors, and volunteers of:

Agency/Provider: _____

Street Address: _____

City: _____ State: _____ Zip: _____

To release/disclose ALL past, current and future:

- **Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA);**
- **Sensitive Information (SI) under various Illinois laws and regulations; and**
- **Education Records (ER) under the Family Educational Rights and Privacy Act of 1974 (FERPA)**

Of and concerning the Participant to the employees, contractors and volunteers of the University of Illinois at Chicago Division of Specialized Care for Children (DSCC) as requested by the DSCC verbally or in writing.

The PHI, SI and ER released/disclosed to the DSCC may be used by the DSCC for the following purpose(s):

☐ Care Coordination/Case Management with the participant's identified providers

☐ Determining DSCC payment for care

☐ Establishing medical eligibility for DSCC services

☐ Other: _____

I specifically authorize the Agency/Provider to release/disclose any and all of the following SI to the DSCC:

☐ Developmental Disabilities ☐ Behavioral/Mental Health ☐ Genetic ☐ Sexual Assault or Abuse

---

The following kind or type of records (or similar records) may also be released/disclosed to the DSCC:

☐ Medical/Clinic/Hospital ☐ Financial/Benefits ☐ Speech/Audiology ☐ Educational

☐ Social Service ☐ OT/PT ☐ Demographic Information ☐ Other:_____

NOTICE REGARDING DSCC's RECEIPT OF PHI, SI, or ER:

- PHI or ER ***released/disclosed to*** the DSCC may no longer be protected by HIPAA or FERPA.
- PHI or ER ***re-disclosed by*** the DSCC may no longer be protected by HIPAA or FERPA.
- SI **released/disclosed** to the DSCC ***cannot be re-disclosed*** by the DSCC without further authorization.

RE-DISCLOSURE AUTHORIZATION

By signing below, I authorize the DSCC to re-disclose all past, current, and future PHI, SI or ER it receives through any and all authorizations with the participant's identified providers (including this authorization with the Agency/Provider identified above) among and between the participant's identified providers for the above authorized purposes, the Participant's Parent/Guardian, and the Participant.

This authorization will expire on the following calendar date: _____

SPECIALIZED CARE FOR CHILDREN

AUTHORIZATION TO RELEASE HEALTH INFORMATION

DSCC# _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

I UNDERSTAND:

- This authorization is voluntary and that I may refuse to sign this authorization.
- Refusing to sign this authorization will not affect my child's ability to obtain treatment, payment, enrollment, or eligibility for benefits, but will diminish the ability, quality and timeliness of the DSCC's services.
- I may withdraw or revoke this authorization at any time by written notice to DSCC (at the address below) unless DSCC has already acted in reliance on it.
- I have the right to inspect and request a copy of any of the information to be released/disclosed/re-released.
- PHI disclosed may no longer be protected by HIPAA.

SIGNATURES

LEGALLY RESPONSIBLE ADULT (PARENT, LEGAL GUARDIAN, OR PARTICIPANT WHO IS MARRIED, AGE 18 OR ABOVE, OR LEGALLY EMANCIPATED):

By signing below, I affirm I am the legally responsible adult listed above and voluntarily consent and fully authorize the releases/disclosures consistent with this authorization.

Legally Responsible Adult: _____ _____
(Signature) (Date)

Witness: _____ _____ _____
(Signature) (Print) (Date)

PARTICIPANT AT LEAST 12 YEARS OF AGE, BUT UNDER 18 YEARS OF AGE:

☐ **I attest the participant has been informed of this authorization and does not object.**

☐ **Participant listed above is cognitively delayed and unable to provide consent for aspects of mental and sexual health; therefore, the parent/guardian is signing below.**

Parent/Guardian:

_____ _____ _____
(Signature) (Print) (Date)

By signing below, I voluntarily consent and fully authorize the releases/disclosures consistent with this authorization.

Participant: _____ _____
(Signature) (Date)

Witness: _____ _____ _____
(Signature) (Print) (Date)

----------***Physical Inability***----------

☐ **Participant (mark):**_____ ☐ **Request fully explained to Participant** _____
(Date)

Witness: _____ _____ _____
(Signature) (Print) (Date)

Witness: _____ _____ _____
(Signature) (Print) (Date)

SEND INFORMATION TO YOUR LOCAL OFFICE:
UIC DIVISION OF SPECIALIZED CARE FOR CHILDREN
ATTN: Records
Champaign Office, 510 Devenshire, Suite A, Champaign, IL 61820-7306