DIVISION OF SPECIALIZED CARE FOR CHILDREN

DSCC# _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

PARTICIPANT INFORMATION

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

Legally Responsible Adult: _____ Relationship: _____

Legally Responsible Adult: _____ Relationship: _____

PERMISSION TO SHARE INFORMATION

By signing this form, I give permission to the below providers to share and disclose my or my child's health and educational records with the University of Illinois Chicago's Division of Specialized Care for Children (DSCC).

This includes sharing and disclosing all past, current, and future health and educational information related to the participant.

Please read carefully. Let your DSCC care coordination team know if you have any questions.

I authorize the employees, contractors, and volunteers of:

PROVIDERS

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

TYPE OF INFORMATION THAT DSCC WILL SHARE OR RECEIVE

The above listed providers can share or disclose these types of information/records with DSCC. DSCC can also share these types of information with the listed providers.

- ☐ Medical/Clinic/Hospital
- ☐ Education
- ☐ Health Insurance Benefits
- ☐ Speech/Audiology
- ☐ Other _____
- ☐ Social Services
- ☐ Financial Records (for DSCC Financial Assistance)
- ☐ Occupation/Physical therapy
- ☐ Demographic Information

I understand that the records may include the following sensitive information:

- ☐ Developmental Disabilities
- ☐ Genetic Testing or Counseling
- ☐ Reproductive Health
- ☐ Sexual Assault or Abuse
- ☐ Behavior/Mental Health
- ☐ Substance Use (Drug/Alcohol)
- ☐ HIV/AIDS testing information or results

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REASON FOR SHARING INFORMATION

DSCC may use the participant's information for the following purposes:

- Care coordination
- Checking medical eligibility for DSCC
- Deciding DSCC payment for care
- Other _____

PERMISSION TO RE-DISCLOSE INFORMATION

By signing below, I give DSCC permission to re-disclose all past, current, and future information DSCC receives through any and all authorizations with the participant's identified providers. This includes the authorization with the agencies and providers identified above for the purposes listed on this form.

If enrolled with Illinois Medicaid or one of Illinois Medicaid's managed care plans, I authorize DSCC to re-disclose all past, current, and future information with Illinois Department of Healthcare and Family Services or the applicable Medicaid managed care organization for the above care coordination, treatment, and payment purposes.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

I UNDERSTAND:

- This authorization is voluntary. I may refuse to sign this form. Refusing to sign this form will not affect the participant's ability to receive treatment, payment, enrollment, or eligibility for benefits from your healthcare providers. Not signing may reduce the ability, quality, and timeliness of DSCC's services. It may impact your ability to enroll and receive DSCC care coordination services.
- I may withdraw or revoke this authorization at any time by providing written notice to DSCC. The revocation is effective only when DSCC receives and acknowledges it.
- I have the right to inspect and request a copy of any of the information to be released, disclosed, or re-released.
- Protected health information disclosed may no longer be protected by HIPAA.

SIGNATURES

This authorization is valid for one year from the signature date unless a different expiration date is entered.

Date (Month/Day/Year): _____

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LEGALLY RESPONSIBLE ADULT

The legally responsible adult should complete this section.

You are considered the legally responsible adult if:

- You are the participant's parent or legal guardian.
- You are the participant and age 18 years of age or older.
- You are under 18 and married, pregnant, or legally emancipated.

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

Legally Responsible Adult: _____ _____

(Signature of Legally Responsible Adult) *(Date)*

Witness: _____ _____ _____

(Witness Signature) *(Printed Witness Name)* *(Date)*

MINOR PARTICIPANTS 12 to 17 YEARS OF AGE

Complete this section for participants who are 12 to 17 years old. If the participant is under 12 or over 18, do not complete this section.

The following information of a participant 12 to 17 years of age (Minor Patient) is restricted as follows:

Drug/alcohol use, AIDS/HIV, or Birth Control/Sexually Transmitted Disease(s)/Sexual Assault, as well as any health information generated as a result of the minor participant's independent legally authorized consent to treatment, requires the minor participant's signature to this release.

Mental health or developmental disabilities information is available after the minor participant's signature has been witnessed or the minor participant's parent or guardian's signature has been witnessed, provided the minor participant has been informed and does not object to disclosure. Otherwise, Illinois law only permits limited mental health or developmental disabilities information to be available to the minor participant's parent or guardian.

By signing below, I affirm I am the participant and voluntarily consent and fully authorize the communication consistent with this consent.

Participant: _____ _____ _____

(Participant Signature) *(Printed Participant Name)* *(Date)*

Witness: _____ _____ _____

(Witness Signature) *(Printed Witness Name)* *(Date)*

☐ Participant is cognitively delayed or unable to provide consent. I, as the legally responsible adult, am signing below.

Legally Responsible Adult: _____ _____

(Signature of Legally Responsible Adult) *(Date)*

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PHYSICALLY UNABLE TO SIGN THE FORM

Use this section if the participant is physically unable to sign the form.

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

Witness: _____ _____ _____

(Witness Signature) *(Printed Witness Name)* *(Date)*

Witness: _____ _____ _____

(Witness Signature) *(Printed Witness Name)* *(Date)*