Family Service Agency
*Strengthening Individuals & Families*

Submit

# Authorization to Release Information

**Client Name:**_____ **Date of Birth:**_____
**Address:**_____ **Phone:**_____
**City, State, Zip:**_____

I hereby give consent to Family Service Agency of DeKalb County, 14 Health Services Drive, DeKalb IL 60115 815-758-8616 to release and/or exchange protected mental health information and/or program information concerning the above named client in written, oral or electronically to the following person or entity:

Agency or Individual: _____

Address, City, State, Zip:_____

Phone:_____ Fax:_____

Information to be released for the following purpose: _____ Student Progress _____ Health care use _____ Legal use
_____ Personal use _____ Referral _____ Continuity of care _____ Other
Treatment date(s): _____ to_____ Expiration date:_____

**Type of Information** (Check all that apply):

_____ Big Brothers Big Sisters _____ Senior Services _____ Treatment Plan _____ Dates of Service

_____ Discharge Summary _____ Treatment Progress/Notes _____ Medication information _____ Client history

_____ Mental Health _____ Intake/assessment _____ Other (specify _____)

_____ HIV Documentation (Client must initial)_____ _____ Substance Abuse (client must initial)_____

_____Children's Advocacy Center: Forensic Interview Disclosure and Services* _____ Financial

*Please note that if Children's Advocacy Center: Forensic Interview Disclosure and Services is selected, this only permits discussion of interview with mental health or medical professionals. Records from the Children's Advocacy Center will not be released without a judge signed subpoena.

I understand that:

- I have the right to obtain a copy of my own protected health information
- I have the right to revoke this authorization at any time, I must do so in writing to the medical records department, I may not revoke for information that has already been authorized and disclosed
- Re-disclosure of information is prohibited without written consent, that being stated, Family Service Agency cannot prevent an entity to which it is disclosing to from re-disclosing the information on their own accord
- Authorizing to disclose protected health information is voluntary and not required for treatment, payment, or benefits
- Form must be filled out in its entirety for request to be honored.
- Fees may be charged for records per all laws applicable to release of protected health information.
- My record may contain information pertaining to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)

_____ _____
Client Signature (Client 12 years of age or over) Date Parent or Guardian signature Date

Clients age 12 to 17 must sign in addition to the parent or guardian.

_____
Relationship to client

_____
Witness Date