State of Illinois
Department of Human Services

Release of Information

I authorize the release of medical, financial, personal and other program information by

_____ agency, the employer agent (ACES$) and by the ILLINOIS DEPARTMENT OF HUMAN SERVICES (DHS). This information may be released for the purposes of determining my eligibility for programs, planning my services and supports and monitoring my service delivery. The information may also be used to audit agencies providing my services and to review programs. Information may be released only if it is necessary to accomplish these purposes.

This release is valid until _____ **(Expiration Date).**

(Must be completed)

Agencies authorized to receive this information are the:

* U.S. Department of Health and Human Services;
* U.S. Social Security Administration;
* Illinois Departments of Human Services, Healthcare and Family Services, and Public Health;
* Other Illinois state agencies that operate a Medicaid Home and Community-Based Services waiver program;
* Illinois State Board of Education; and
* Local agencies under contract with DHS for the provision of service coordination, employer agent services or other supports and services which are involved in my individual service plan.

I understand that I have the right to look at and copy information about me that is released. I also understand that I have the right to refuse to release information but that DHS may still release information according to the Confidentiality Act and the federal Health Insurance Portability and Accountability Act (HIPAA).

Name of Individual (print or type): _____

Signature of Individual or authorized representative: _____

Signature of Witness: _____ Date: _____

CONFIDENTIALITY OF INFORMATION - Information received about the individual is to be handled in accordance with the requirements of the Mental Health and Dvelopmental Disabilities Confidentiality Act (740 ILCS 110) and the federal Health Insurance Portability and Accountability Act (HIPAA).

(formerly DMHDD - 1214)

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