State of Illinois
Department of Human Services

4 (12 Months)

Authorization to Release Medical Records

Section A: Individual for whom medical records are being requested.

First Name: _____ Middle Name: _____ Last Name: _____

Previous Name (if applicable): _____

Street Address: _____ Date of Birth: _____

City/State/Zip: _____ Daytime telephone number(s): _____

Section B: Person or organization from whom medical records are requested.

Hospital/agency/clinic/physician: _____ Attention: _____

Address: _____

Phone: _____ Fax: _____

Section C: Send requested medical information to:

Illinois Department of Human Services
FCRC: _____ Attention: _____

Address: _____

Phone: _____ Fax: _____ TTY: _____

Section D: Information to be disclosed from DATE (or RANGE OF DATES) Date: _____

Check information needed.

- ☐ History and Physical
- ☐ Pathology Reports
- ☐ Consultation Reports
- ☐ Behavior Plans
- ☐ Physician's Discharge Summary
- ☐ Progress Notes
- ☐ Psychiatric Evaluation
- ☐ Mental Health Record
- ☐ Emergency Department Record
- ☐ Rehab Records
- ☐ Psychiatric Outpatient Notes (pre/post hospitalization)
- ☐ Diagnostic Test Reports
- ☐ Social History
- ☐ Developmental Disabilities Records
- ☐ Alcohol/substance Abuse
- ☐ HIV/AIDS
- ☐ Other: _____

Section E: Expiration of Authorization.

This authorization is valid until calendar date: (Month/Day/Year) _____

Unless an earlier date is specified, this authorization will expire 12 months from date of signature below.

Section F: Signature.

(a) If the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described in Section D may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from re-disclosing mental health, developmental disability, substance abuse or AIDS related information under the Federal Substance Abuse Act 42CFR Part 2, Confidentiality Requirements, the Illinois Mental Health and Developmental Disabilities Confidentiality Act and the Illinois AIDS Confidentiality Act.

(b) The person I am authorizing to use the information may receive compensation for doing so.

(c) I may inspect and copy the information disclosed.

(d) Payment of a claim, enrollment, or eligibility for benefits will not be affected if I do not sign this form unless the disclosures are necessary to determine payment, eligibility or enrollment, or for disability re-determinations.

(e) I may revoke this authorization at any time. The revocation must be in writing and must be sent/given to the records department named in Section B. It will not affect action already taken before the revocation is received.

Signature of Individual: _____ Date: (Month/Day/Year) _____

Signature of Representative: _____ Date: (Month/Day/Year) _____

Authority to represent individual: ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Authorized Representative

Signature of Witness (or 2nd parent/guardian): _____ Date: (Month/Day/Year) _____

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Section G: Revocation Section. If completed, send copy of entire form to person or organization named in Section B.

I no longer want health information pertaining to the person named in Section A shared with the Department of Human Services. I understand action already taken before the revocation is received is not affected.

Signature of individual or authorized representative: _____ Date: (Month/Day/Year) _____

Authority to represent individual: ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Authorized Representative

INSTRUCTIONS: AUTHORIZATION TO RELEASE MEDICAL RECORDS

GENERAL

Ask individual to sign a separate form for each provider. Keep original signed form in the customer's case record. Attach a copy of signed Form 4701H to Form 183A sent or given to the provider. Include a copy of each signed Form 4701H with packet sent to CAU.

Section A - Information about individual.

Complete information about the person for whom medical records are requested. This may or may not be the customer, depending on the program (ex. TANF family care barrier). Fill in Previous name if the individual has married, or has used other names during the period information is requested in Section D.

Section B - Information about provider.

Complete information about medical provider from whom medical records are requested. If known, fill in ATTN with the name of an individual or department within the organization to expedite request.

Section C - DHS contact information.

Complete DHS contact information. This is the address or fax number which the provider will use to return records.

Section D - Authorization period and information to be disclosed.

Must include a beginning date or range of dates for which medical records are requested. If there is no specific onset date, go back 12 months for the beginning date. Check the items which are necessary to determine eligibility. If unsure what information is needed, check with the Client Assessment Unit (CAU).

Section E - Expiration of authorization.

Complete with date which is no later than 12 months from date the form is signed.

Section F - Signature.

(a) Client information is private and is used by the Department, contracted providers, and others strictly for the administration of our programs, with certain exceptions specified by law. (PM 01-01-04)
(b) Self-explanatory.
(c) Self-explanatory.
(d) If medical records are necessary to determine program eligibility, failure to sign this authorization will affect eligibility for benefits.
(e) This authorization may be revoked before expiration by completing Section G and sending to the provider.

The authorization must be signed by the individual (or the individual's representative) for whom medical records are requested in Section A. This may or may not be the customer, depending on program (ex. TANF family care barrier) . If under age 18 or legally disabled, a parent/ guardian signature is required. The signature of a minor who is age 12 or older may also be required. If it is difficult to obtain the individual's signature, check with the provider to learn if the authorization will be accepted with the representative's signature. Include proof of the legal representative's authority. Must be signed by a witness who can attest to the identity of the person signing the authorization.

Section G - Revocation of authorization.

If the individual does not want a provider to release further information, instruct the individual or representative to complete this section on original form. Copy entire form and send to provider specified in Section B. Medical information which has already been released before the provider receives the revocation may still be used for purposes previously authorized.