



### Authorization for Release of Information and Assignment of Benefits

I authorize the Department of Human Services (Department) to release all medical, mental health or psychiatric, social, and financial information necessary for the application of the following benefits: SSA, SSI, insurance Veteran's, Public Assistance, Medicare, Champus, to the Social Security Administration or its intermediaries or carriers; any private insurance carrier/employer; Champus/Veterans Administration, or the Illinois Department of Public Aid, or to the Centers for Medicare and Medicaid Services; various Peer Review Organizations and other auditors and reviewers required by federal laws and regulations to audit, certify, and verify that federal benefit funds were properly used.

I request that my payments of benefits from Medicare, insurance, Champus be paid on my behalf to the Department of Human Services.

I authorize the Social Security Administration to release information to the Department of Human Services concerning my current benefit status.

I understand that, unless revoked by me, this consent will remain in effect for this admission until two years from the date signed.

I understand that I may revoke this consent at any time and that the above named organization authorized to receive this information has the right to inspect and copy the data disclosed.

I understand that the purpose of this authorization is to secure the funds to be applied to the cost of services provided to me.

It is my full understanding that the records and communications to be disclosed contain evaluation and/or habilitation/treatment information for mental health, developmental disabilities and/or alcohol substance abuse and that my signature indicates my informed consent. HIV/AIDS information will not be released unless specifically requested.

It has been explained to me that, if I refuse to consent to this release of information, the Department's inability to secure third-party payments to apply to service costs will result in greater assessment against other assets and/or income.

I understand the Department is authorized to release such information deemed necessary to collect sums representing my service charges without my expressed consent if I fail to pay such sums.

I also understand that the information I provide on this form is protected by privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) [P.L. 104-191] at 45 CFR 160 and 164). My personally identifiable health information will only be used and/or released in accordance with HIPAA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

Identification: \_\_\_\_\_ Admission Date: \_\_\_\_\_ Name: \_\_\_\_\_

Signature of Individual

Date: \_\_\_\_\_

Guardian's Name

Signature of Guardian

Date: \_\_\_\_\_

Witness's Name

Signature of Witness

Date: \_\_\_\_\_

for DHS use only: authorization code \_\_\_\_\_ Effective from \_\_\_\_\_ through \_\_\_\_\_

A copy of this form was provided to the individual or his/her authorized representative in  English  Spanish

Other (specify) \_\_\_\_\_ by \_\_\_\_\_ on \_\_\_\_\_  
(Name) (Title) (Date)

NOTICE TO RECEIVING AGENCY/PERSON: Under penalty of law and provisions of the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.