ILLINOIS DEPARTMENT OF
Healthcare and Family Services

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NOTICE:

- Federal law says that the Agency cannot share your Health Information without your permission except in certain situations. If you sign this form, you are giving Healthcare and Family Services permission to share your Health Information that Healthcare and Family Services has with the person you indicate below.
- This Authorization is voluntary.
- **Right to Revoke**: If you decide you do not want Healthcare and Family Services to share your Health Information any longer, sign the Revocation at the end of this form and give this form to Healthcare and Family Services. If Healthcare and Family Services has shared your Health Information for a research study, Healthcare and Family Services may continue to use or share your Health Information for that purpose only.
- Payment, enrollment or eligibility for benefits for your health care will not be affected if you do not sign this Authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.
- Healthcare and Family Services cannot promise that the person you permit Healthcare and Family Services to share your Health Information with will not share your Health Information with someone else you may not want to have your Health Information.
- You can keep a copy of this Authorization, and can contact the Healthcare and Family Services Privacy Officer to get a copy if you do not have one.

My name: (print).. Date of birth: ....

Social Security Number: .... Recipient I.D. Number (RIN): ....

I give permission to: **Healthcare and Family Services** to share my Health Information with:

.... so that this person or entity may assist me with my health care issues.

Healthcare and Family Services may share my Health Information for one year after the date on this Authorization form or until I revoke the Authorization.

I want Healthcare and Family Services to share this Health Information: **(check all boxes that apply)**

❏ All of my Health Information
❏ Information regarding prescription drug coverage
❏ My Health Information regarding acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)
❏ My Health Information regarding treatment for alcohol and/or substance abuse
❏ My Health Information regarding behavioral health services or psychiatric care
❏ Other: ....

This form must be signed by EITHER the Recipient OR by the Personal Representative. The Recipient's parent may sign for the Recipient if the Recipient is a minor.

Signature of Recipient: .... Date: ....

If this form is signed by the Personal Representative, please include a copy of the document naming the Personal Representative, for example, a Power of Attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of Personal Representative: .... Date: ....

Relationship of Personal Representative: ....

REVOCATION OF AUTHORIZATION:

I no longer want Healthcare and Family Services to share my health information with the person or entity indicated above.

My name: ....
(print)

Social Security Number: ....

Signature: .... Date: ....

Send this **Authorization Form or Revocation of Authorization** to:

Privacy Officer
Healthcare and Family Services
P.O. Box 19159
Springfield, Illinois 62794-9159

Fax: 1-312-793-2005

Contact Healthcare and Family Services Privacy Officer:

P.O. Box 19159
Springfield, Illinois 62794-9159

Toll-free telephone: 1-800-226-0768
(Health Benefits Hotline)

Toll-free for persons using a TTY: 1-877-204-1012
Fax: 1-312-793-2005
e-mail address: privacy.officer@illinois.gov