Family Service Association of Greater Elgin Area
1140 N. McLean Blvd, Suite I, Elgin, IL 60123 (847) 695-3680

Consent for Release of Confidential Information

I hereby authorize Family Service Association of Greater Elgin Area staff to release/exchange written, oral, or electronically transmitted protected health related information about:

Name: _____ DOB: ____/____/____

To: Name/Organization: _____

Information to be released/exchanged: (check all that apply)
□ Comprehensive Assessment □ Treatment Plan □ Progress Notes □ Substance Abuse
□ Psychiatric Evaluation/Notes □ Discharge Summary □ Social History □ Medical Information
□ Other Please Specify: _____

For the purpose of:
□ Exchange of information □ Continuity of Care □ Case Management/Consultation
□ Other Please Specify: _____

This authorization to release information expires: ____/____/____ (not to exceed one year)

- I understand that the above named person/organization authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Regulations.

- I understand that I may revoke this consent at any time; however, the revocation must be in writing. I understand that no revocation of this consent shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

- Refusal to consent to release of information will result in the following consequences: INFORMATION WILL NOT BE RELEASED which may result in inability to provide effective service coordination.

- It is my full understanding that the records and communications to be disclosed may contain evaluation and/or treatment information for mental health, developmental disabilities and/or alcohol or substance use/abuse and that my signature indicates my informed consent.

- I understand that I can inspect and/or copy information before it is released by making my request in writing. In addition, I understand that I can request a copy of this release of information.

_____ _____
Client Signature (age 12 and older) Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

NOTICE TO RECEIVING PERSON/ORGANZIATION: If you are a healthcare provider, you are subject to the HIPAA Privacy Rule related to re-disclosure of information. Under the Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, that no such records, nor information from such records may be further disclosed without the specific authorization from the individual for such re-disclosure. (Revised 10/12)