Consent For Release of Information

Client Name: _____ **Date of Birth:** _____

Having been fully informed of the policies and procedures of JCFS Chicago (JCFS) regarding the authorization and/or request for release of information as stated*, I hereby authorize JCFS Chicago to release information to:

☐ Myself via encrypted email ☐ Myself at the address on file ☐ Parent/guardian on record named: _____

_____ _____ _____

or Person/Agency Address phone number

I authorize the following information to be disclosed:

☐ Mental Health (specify): Educational and psychiatric diagnoses related to educational planning; former educational and mental health treatment related to school; all 3rd party psychological or psychiatric reports provided to JCFS School by guardians.

☐ Medical Information (specify): current physical, dental, immunization records, other applicable medical information related to IEP, all 3rd party reports provided to Knapp School by guardians

☐ Psychiatric/Psychological reports (specify): Verbal &/or written progress reports; all 3rd party reports provided to JCFS School by guardians, notification of psychiatric hospitalization, if applicable.

☐ Education (specify): transcripts, IEP, FIE, educational testing, academic and behavioral reports, all 3rd party reports provided to JCFS School by guardians

☐ Financial (specify): _____

☐ Service/Treatment history (specify): Educational and mental health history as related to provision of educational services

☐ Referral information (specify): Information required for admission to the school

THE PURPOSE FOR REQUESTING THIS INFORMATION:

☐ Pre-admission/Referrals ■ Coordination of treatment/services ☐ Payment

☐ Legal Proceedings ☐ Other (specify): _____

I request the following restrictions to the use or disclosure of my protected health information:

_____

All information released is done in a manner that is consistent with Illinois Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 100/5(d) (1994) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. It is understood that the person authorizing release of this information has the right to inspect and copy the information to be disclosed. The receiving party may not redisclose any of this information unless the person who consented to this disclosure consents to such redisclosure.

The consequences, if any, of not signing this release are: inability to coordinate services

This consent is valid only for the date it is signed unless specified here until_____(not to exceed one year) and may be revoked with written consent at any time except to the extent that action has already been taken.

_____ _____

(signature of client – adult or child over 12) (date)

_____ _____

(signature of parent/legal guardian) (date)

*Information can be found in JCFS Chicago's HIPAA Privacy Policy

JCFS CHICAGO