Easter Seals DuPage and the Fox Valley Region

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AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Section A: Client complete for all authorizations. Please check and initial statement(s) that applies.

[ ] I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is **voluntary**. I understand that if the organization authorized to **receive** the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations. Initials: _____

[ ] I hereby authorize Easter Seals DuPage and the Fox Valley Region (ESD&FVR) to obtain individually identifiable health information as described below. I understand that this authorization is **voluntary**. Information obtained will be for the sole use of 'ESD&FVR' to provide treatment, receive payment or for health care operations purposes. Initials: _____

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

'ESD&FVR' may release to or obtain from as indicated below (physician(s), healthcare providers, educational program(s), or other agencies) my health information.

_____
Name, Address, Phone, Fax

_____
Name, Address, Phone, Fax

_____
Name, Address, Phone, Fax

_____
Name, Address, Phone, Fax

Description of information to be disclosed or obtained:

[ ] Evaluation/Assessment [ ] Progress Notes/Summary [ ] Medical History [ ] Discharge Reports
[ ] Psychological Reports [ ] IEP/School Records [ ] Medical Consultation [ ] Physical/Immunization Records
[ ] Other as here specified _____

Client or the Client's representativeread and initial the following statements:

1. I understand that this authorization will expire within one year from today's date. Initials: _____

2. I understand that I may revoke this authorization at any time by notifying 'ESD&FVR' in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions 'ESD&FVR' took in reliance upon my authorization before it received my revocation. Initials: _____

   You may revoke this authorization by making a written request of Revocation of Authorization. Please address your Request for Revocation of Authorization to: Easter Seals DuPage and the Fox Valley Region, 830 S. Addison, Villa Park, IL 60181, Attn: Privacy & Security Officer.

3. 'ESD&FVR' will not condition your treatment or payment for your health care services on your completing and signing this authorization.

Easter Seals DuPage and the Fox Valley Region personnel to complete for requests to obtain information:

1. The purpose of the use or disclosure is: [ ] Program Planning [ ] Other _____

2. Easter Seals DuPage and the Fox Valley Region _ will **X will not** receive direct or indirect compensation in exchange for using or disclosing the information listed above.

NOTICE TO CLIENT: You or your representative may inspect and/or copy the health information in accordance with 'ESD&FVR's policies.

Section B: Must be completed by client or client representative for all authorizations.

_____ _____
Signature of Client or Client's Representative **Date**

_____ _____
Client's Representative Name *(Please Print)* **Relationship to Client**

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION