**NAME: DATE OF BIRTH:**

**I am allowing these providers to communicate and exchange information for the purpose of:**

[ ]  Coordinating Services [ ]  Assisting in Treatment [ ]  Assessing Progress

[ ]  Other purpose, please specify:

**I am authorizing the following providers to communicate and exchange information with each other. I have provided the name and number of the entity and a contact person:**

[ ]  Baby Fold [ ]  Medical Provider

[ ]  Chestnut Health Systems [ ]  Police Department

[ ]  Children’s Home & Aid [ ]  Project Oz

[ ]  Community MH Center [ ]  Resource Link

[ ]  Court Services [ ]  School District

[ ]  CYFS [ ]  Special Ed Cooperative

[ ]  DCFS [ ]  Other

[ ]  Health Department [ ]  Other

[ ]  Hospital [ ]  Other

**NATURE OF INFORMATION:** [ ]  Special Education File [ ]  AIDS/HIV [ ]  Attendance

[ ]  Classroom Observation [ ]  Court Service Reports [ ]  Developmental History [ ]  Diagnosis

[ ]  Discharge Summary [ ]  Discipline Record [ ]  Emergency Department Records [ ]  Genetic Testing

[ ]  Hg/Lead Labs [ ]  Intake Summary [ ]  Legal Records [ ]  Medical History

[ ]  Medications [ ]  Prognosis [ ]  Psychiatric Consultations [ ]  Psychological Evaluation

[ ]  Recommendations [ ]  Referral Paperwork [ ]  Substance Abuse [ ]  Screening Data

[ ]  Sex Abuse/Assault records [ ]  Social History [ ]  Academic Reports/Transcripts [ ]  Treatment Plan

[ ]  Contact/Progress notes [ ]  Assessment [ ]  Financial/Insurance Information

[ ]  Other [ ]  Other

**FORM OF COMMUNICATION:** [ ]  Spoken [ ]  Written [ ]  Other

**MY SIGNATURE BELOW WILL INDICATE THAT I HAVE READ AND UNDERSTAND THE INFORMATION THAT FOLLOWS:**

That information will only be disclosed when this document is completed and signed by me and witnessed, except as provided by Federal and State Regulations on confidentiality.

1. That this consent may be modified or revoked by me at any time upon written request to the party releasing the information, except to the extent that action has already been taken in reliance on this authorization.
2. That this consent automatically expires one year from date of client’s signature or on whichever is earlier.
3. That I have the right to inspect, challenge and/or copy information to be released. I can limit records or parts of records to share.
4. That my provider cannot condition my treatment, payment, enrollment or eligibility for benefits on whether or not I sign this form. Further, that failure to consent to such a release of information may have an impact on the quality of services to be provided, but will not be grounds for termination of services.
5. The agency/person receiving information under the terms of this consent are not allowed to further release or disclose said information to any other entity without my specific written consent.

**EFFECT OF GRANTING THIS AUTHORIZATION:** The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and federal health information privacy laws may no longer protect it. However, any mental health, substance abuse, genetic testing, or HIV/AIDS information disclosed pursuant to this authorization may not be further disclosed except pursuant to my authorization. I am willing that a reproduction of this consent be accepted with the same authority of the original.

CLIENT:

 *Signature Date*

REPRESENTATIVE:

 *Printed Name Signature Date Relationship to Client*

WITNESS:

 *Printed Name Signature Date Agency*

***Notice to Receiving Agency/Person:***Under the provisions for the Mental Health and Developmental Disabilities Confidentiality Act, you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such a redisclosure. The information that I am permitting to be disclosed may be from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further redisclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 12/1/16