Lutheran Social Services of Illinois

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ _____/_____/_____
[Client Name] [Date of Birth MM/DD/YYYY]

I, _____, authorize Lutheran Social Services of Illinois ("LSSI")
[Name of Client, Parent, Guardian or Personal Representative]

To Disclose/Exchange/Release to Records Deposition Service, P.O. Box 5054, Southfield, MI 48085-5054 F: (248) 357-3337, E: requests@recdep.com the following information:
[Name or Title of Person or Organization]

DESCRIPTION OF INFORMATION TO BE DISCLOSED (check all that apply)

☐ ALL TREATMENT RECORDS, including substance use disorder records and mental health records (If this box is checked, LSSI will tender all records in its possession)

☐ Assessment
☐ Diagnosis
☐ Psychiatric Evaluation/Assessment
☐ Treatment Plan or Summary
☐ Current Treatment Update
☐ Psychiatric or Progress Notes
☐ Social History
☐ Medication Information
☐ Attendance /Participation in Treatment
☐ Physical Examination
☐ Mental Status Exam
☐ Medical Information
☐ Drug/Alcohol History
☐ Toxicological Reports/Drug Screens
☐ Prognosis
☐ Recommendations
☐ Discharge/Transfer Summary
☐ Continuing Care Plan
☐ Progress in Treatment
☐ Demographic Information
☐ Financial
☐ Insurance
☐ Collateral Contact Interview
☐ Other _____
☐ Other _____
☐ Other _____

Dates of Service/Treatment to be Disclosed (Past/Current/Future Treatment): _____
_____

PURPOSE

The purpose of this disclosure is: LEGAL DISCOVERY

REVOCATION

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the Program Director or Supervisor. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

EXPIRATION

This authorization expires on the following date: _____/_____/_____ (Not to exceed 12 months from date of signature)

CONDITIONS

I understand that:

1. I have the right to inspect and copy the information to be disclosed;
2. Treatment records remain confidential, and may not be re-disclosed or re-released without my written consent unless otherwise authorized by law; and
3. I am under no obligation to sign this Authorization. I further understand that Lutheran Social Services of Illinois will not condition my services on whether I give authorization for the requested disclosure. However, it has been explained to me that the following are consequences of my not signing:
   _____.

FORM OF DISCLOSURE

Unless you have specifically requested in writing that the disclosure be made in a certain format, LSSI reserves the right to disclose information as permitted by this Authorization in any manner that it deems to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically. There may be a fee for photocopying. A photocopy or facsimile of this Authorization shall be as valid as the original.

RE-DISCLOSURE

Notice to Receiving Agency: 42 CFR Part 2 prohibits unauthorized disclosure of these records. Certain state laws may also restrict re-disclosure of information without written consent.

CRIMINAL JUSTICE

If I am involved in the criminal justice system, I give consent to LSSI to disclose my records authorized by this disclosure to_____(insert name of parole or probation officer) to coordinate care and manage my court supervised treatment. I further consent to the redisclosure of these records within the criminal justice system to carry out the stated purpose. I understand that I may not revoke my consent until there is a final disposition of my conditional release or other action in connection with which consent was given.

I will be given a copy of this Authorization for my records.

_____ _____

[Signature of Client] **[Date]**

_____ _____

[Signature of Parent, Guardian or Personal Representative*] [Date]

*If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ _____

[**Signature of Witness Attesting to Identity & Authority**] [**Date**]

CERTIFICATION OF INTERPRETATION

I certify that I have read the foregoing to the signatory hereof in the _____ language.

_____ _____ _____

[Interpreter] [Date]

FOR ADMINISTRATIVE PURPOSES ONLY. DO NOT COMPLETE WITHOUT STAFF ASSISTANCE

WITHDRAWAL OF CONSENT

I hereby revoke my authorization to release information.

_____ _____

[Signature of Client] [Date]