State of Illinois
Department of Healthcare and Family Services

Authorization To Disclose Health Information

NOTICE:

- Federal law says that Healthcare and Family Services (HFS) cannot share your health information without your permission except in certain situations. If you sign this form, you are giving HFS permission to share your health information that HFS has with the person you indicate below.
- This authorization is voluntary.
- Right to revoke : If you decide you do not want HFS to share your health information any longer, sign the revocation at the end of this form and give this form to HFS. If HFS has shared your health information for a research study, HFS may continue to use or share your health information for that purpose only.
- Payment, enrollment or eligibility for benefits for your health care will not be affected if you do not sign this authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.
- HFS cannot promise that the person you permit HFS to share your health information with will not share your health information with someone else you may not want to have your health information.
- You can keep a copy of this authorization, and can contact the HFS privacy officer to get a copy if you do not have one.

My name (print) _____ Date of Birth _____

Social Security Number _____ Recipient I.D. Number _____

I give permission to: **Healthcare and Family Services** to share my health information with:

_____

so that this person or entity may assist me with my health care issues.

HFS may share my health information for one year after the date on this authorization form or until I revoke the authorization.

I want HFS to share this health information: **(check all boxes that apply)**

- ☐ All of my health information
- ☐ Information regarding prescription drug coverage
- ☐ My health information regarding Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
- ☐ My health information regarding treatment for alcohol and/or substance abuse
- ☐ My health information regarding behavioral health services or psychiatric care
- ☐ Other _____

This form must be signed by EITHER the recipient OR by the personal representative. The recipient's parent may sign for the recipient if the recipient is a minor.

Signature of Recipient _____ Date _____

If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a power of attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of personal representative _____ Date _____

Relationship of personal representative _____

REVOCATION OF AUTHORIZATION

I no longer want Healthcare and Family Services to share my health information with the person or entity indicated above.

My name (print) _____

Social Security Number _____

Signature _____ Date _____

Send this **Authorization Form** or **Revocation of Authorization** to:

Privacy Officer
Office of the General Counsel
Healthcare and Family Services
201 S. Grand Ave. East, 3rd Floor
Springfield, IL 62763-1000

Fax: 1-217-524-2397

If you have any questions, contact the Privacy Office at the address to the left, or the phone number below. The call is free.

Toll-free telephone: 1-800-226-0768
(Health Benefits Hotline)
Toll-free for persons
using a TTY: 1-877-204-1012

e-mail address: HFS.privacy.officer@illinois.gov