Authorization for Disclosing or Obtaining Information

1) I authorize _____ to: ◯ Disclose ◯ Obtain
Individual/Agency

2) An Illinois Medicaid Assessment of Needs and Strengths (IM+CANS) and any associated documentation within the Illinois Department of Healthcare and Family Services (HFS) IM+CANS online portal.

Concerning the care of the below named person from _____
(Date or Range of Dates of Service

3) About: _____
Name of Client

Recipient Identification Number: _____

Date of Birth: _____

Alias (if applicable): _____

4) For purposes of: ◯ Continuity of Care ◯ Addition of New Provider

5) Information will be: ◯ Disclosed To ◯ Obtained From

Name: _____

Address: _____

City/State/Zip: _____

6) This authorization is valid for one year, or until an otherwise specified date: _____

7) It is my full understanding that the records and communications to be disclosed will be the full contents of IM+CANS and any associated documents concerning the above-named individual.

8) It is my full understanding that by signing this documentation, I am agreeing to disclose Personal Health Information to the above-named individual/agency. This Personal Health Information may include, but is not limited to, the following:
   a. The Full IM+CANS document, including the mental health assessment and treatment plan, which includes:
      i. Habilitation/treatment information and history for mental health, developmental disabilities, alcohol or substance use/abuse;
      ii. Mental Health Diagnoses;
      iii. Current and past service history.
   b. The full contents of the Health Risk Assessment (HRA), which includes:
      i. Current and previous medical history;
      ii. Information pertaining to HIV/AIDS;
      iii. Current and previous history of hospitalizations and their purpose.

9) I understand that the above-named individual/agency authorized to receive this information has the right to inspect, copy, and updated the information disclosed.

10) I further understand that if the entity receiving this information is not a healthcare provider/plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA regulations.

11) I understand that I may revoke this authorization; however, the revocation must be in writing and must be sent/given to the individual/agency's records department. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

12) I understand that refusal to sign this document will result in the following consequences:
    a. INFORMATION WILL NOT BE DISCLOSED OR OBTAINED

Authorization for Disclosing or Obtaining Information Signatures		
By signing this document, you agree that you have participated in the mental health assessment and treatment planning process and have been given a copy of the completed IM+CANS. You agree that you have had a chance to review the IM+CANS in full, and that the contents have been explained to you in language that you understand. You understand the risks and benefits of the services outlined in the treatment plan and consent to the services outlined in the treatment plan. *You further agree that you have had a chance to review the* ***Authorization for Disclosing or Obtaining of Information*** *document in full, and that contents of the document and consequences of not signing the document have been explained to you in language that you understand.* *You further agree that the information and data shared within the IM+CANS and associated documentation will be provided to the Illinois Department of Healthcare and Family Services via an online portal, and that the Illinois Department of Healthcare and Family Services may use the data obtained from the IM+CANS portal to condition treatment, enrollment, or determine eligibility for services. You further understand that the Illinois Department of Healthcare and Family Services may share this data with third-party organizations for research related purposes.* *You understand that by not signing this document, the provider or entity may not be able to provide you services as funded by the State of Illinois or it's Managed Care Organizations.*		
CLIENT SIGNATURE *(signature of individual age 12 or older)*		
Client (print name)	*Signature*	*Date*
PARENT/LEGAL GUARDIAN SIGNATURE *(if applicable)*		
Parent/Legal Guardian (print name)	*Signature*	*Date*
STAFF SIGNATURE *(signature of staff member assisting individual/parent/legal guardian)*		
Staff (print name)	*Signature*	*Date*