HFS
Illinois Department of
Healthcare and Family Services

We improve lives.

Authorization to Disclose IM+CANS Information

1) Customer Name: ______________________________
   Date of Birth: _________________________________
   Recipient Identification Number: ___________________
   Alias (if applicable): ____________________________

2) I authorize the Illinois Department of Healthcare and Family Services (HFS) to disclose the Illinois Medicaid Assessment of Needs and Strengths (IM+CANS) and any associated documentation within the HFS IM+CANS online portal to the following provider:

   Name: _________________________
   Address: _______________________
   City/State/Zip: ____________________

3) This disclosure is made for the purpose of treatment and continuity of care.

4) This authorization is valid until ______________________
   (insert calendar date)

5) I understand that the records and communications to be disclosed will be the full contents of the IM+CANS and any associated documents concerning the above-named individual, which may include, but is not limited to, the following:
   i. The full IM+CANS document, including the mental health assessment and treatment plan, which includes:
      a. Habilitation/treatment information and history for mental health, developmental disabilities, alcohol or substance use;
      b. Mental health diagnoses;
      c. Current and past service history.
   ii. The full contents of the Health Risk Assessment (HRA), which includes:
      a. Current and previous medical history;
      b. Information pertaining to HIV/AIDS;
      c. Current and previous history of hospitalizations and their purpose.

6) I understand that the person or agency authorized to receive this information has the right to inspect, copy, and update the information disclosed.

7) 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.

8) I understand that I may revoke this authorization; however, the revocation must be in writing and must be sent to HFS Bureau of Behavioral Health at the contact information below. 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.

Illinois Department of Healthcare and Family Services
ATTN: Bureau of Behavioral Health
201 South Grand Ave. East
Springfield, IL 62704

Or via email at:
HFS.IATP@illinois.gov

9) I understand that refusal to sign this document will result in the following consequences: (1) Information will not be disclosed; and (2) the provider may not be able to provide services funded by the State of Illinois or it's Managed Care Organizations.

Authorization to Disclose IM+CANS Information

You agree that you have had a chance to review the ***Authorization to Disclose IM+CANS 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.*

By signing this document, you agree for the Illinois Department of Healthcare and Family Services to release the full contents of the IM+CANS of the person identified in Section 1 to the provider identified in Section 2 of this ***Authorization to Disclose IM+CANS Information.*** *I understand that the contents of the IM+CANS will not be released to any other providers except those identified in Section 2.*

CUSTOMER SIGNATURE *(signature of individual age 12 or older)*

Customer (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*

Instructions for completing the Authorization to Disclose IM+CANS Information

- Provide individuals signing this consent with a copy of it to keep for their records.
- In order for consent to be valid, all required information in Paragraphs 1, 2, and 4 must be complete and the signatures must be obtained as instructed below.
- Paragraph 1: Complete the customer's full name, date of birth, RIN, and alias (if applicable). HFS must have 3 pieces of demographic information in order to correctly identify the customer.
- Paragraph 2: Complete the provider's name and address to whom the information will be disclosed.
- Paragraph 4: Complete the calendar date for the expiration of the consent. A calendar date must be completed in this section in order for the consent to be valid. The calendar date may specify any time frame the individual chooses but a time frame such as 3-5 years from the date of execution is recommended to minimize the need for repeated signing of the consent.
- Signature section:
    - If the customer is at least 12 years old, but less than 18 years old: Both the child and parent or guardian should sign the signature section. If this section is signed by a person other than a parent, please attach a copy of the document showing the representative's signature authority, such as a power of attorney or order appointing a guardian.
    - If the customer is 18 years old or older: The customer should sign the "Customer Signature" section.
    - If the customer is 18 years old or older, but lacks decisional capacity: The representative should sign the "Parent/Legal Guardian Signature" section, and attach a copy of the document showing the representative's signature authority, such as a power of attorney or order appointing guardian.
    - For all customer: The "Staff Signature" section should be signed by the staff member assisting the customer.