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WILL COUNTY MENTAL HEALTH COURT
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the U.S. Department of Health and Human Services at 45 CFR §164.508 (pursuant to HIPAA, the federal Health Insurance Portability and Accountability Act of 1996), 42 CFR Part 2 (pertaining to the confidentiality of drug and alcohol abuse records), and applicable state law (including but not limited to 20 ILCS 301/1-1 et seq).

I AUTHORIZE AND DIRECT THESE FOLLOWING PROVIDERS:

Provider, Agency, or Facility (including any of its subsidiaries or affiliates or staff)	Dates of Service

TO RELEASE INFORMATION ABOUT OR DISCLOSE FROM THE RECORD OF:

PATIENT / RECIPIENT:_____DATE OF BIRTH:_____

ADDRESS:_____PHONE:_____

TO:

□ The Will County Mental Health Court Team, 14 W. Jefferson Street, Joliet, Illinois 60432, Attn: Judge Domenica Osterberger. ***I understand the following information agencies and their staff may discuss, disclose, and transfer the information or records among themselves as the Will County Mental Health Court Team and I do not consider those discussions to be a re-disclosure as each agency is authorized to receive the information or records. I understand the Will County Mental Health Court Team necessarily includes the following agencies and I intend for the information to be released to any of the agencies in their capacity as part of the Will County Mental Health Court Team:*** The Twelfth Judicial Circuit of Illinois, 14 W. Jefferson Street, Joliet, Illinois 60432 and/or its staff; the Will County Public Defender's Office, 58 E. Clinton Street, Joliet, Illinois 60432 and/or its staff; the Will County State's Attorney's Office, 121 N. Chicago Street, Joliet, Illinois 60432 and/or its staff; the Will County Health Department, 501 N. Ella Avenue, Joliet, Illinois 60433 and/or its staff; the Will County Probation Department, 57 N. Ottawa Street., Joliet, Illinois 60432 and/or its staff; the Will County Center for Correctional Concerns, 95 S. Chicago Street, Joliet, Illinois 60432 and/or its staff; the Will County Adult Detention Facility, 95 S. Chicago Street, Joliet, Illinois 60432 and/or its staff and contractors, including but not limited to Medical.

THE FOLLOWING INFORMATION OR RECORDS:

□ I wish to have all protected health information released (including but not limited to diagnosis, treatment, assessments, referrals, payments, records from other providers, etc.) except as may be otherwise provided.

To the extent any such information exists, pursuant to this authorization:

□ I wish to release HIV/AIDS information.

□ I wish to release developmental disability and/or mental health information (exclude psychotherapy notes).

□ I wish to release information about drug/alcohol abuse diagnosis, treatments, assessments, or referrals.

Note: If you place any restrictions on the release of your protected health information, you will not be able to participate in the Will County Mental Health Court, including the Will County Health Department's Forensic Program, although your treatment by providers not offered through the Will County Mental Health Court will not be affected. A decision to participate in the Will County Mental Health Court places responsibility for use and release of this information under your control.

INFORMATION OR RECORDS MAY BE RELEASED IN THE FOLLOWING FORMS:

□ Oral □ Photocopy □ Written □ Electronic □ Other (*specify*) _____

PURPOSE OF DISCLOSURE:

I submit this request because I want my protected health information to be disclosed to the Will County Mental Health Court Team for the purposes of (a) coordinating treatment services; (b) providing referral information; and (c) monitoring for compliance with a treatment program and my contractual agreement, including informing the Will County Mental Health Court Team of my diagnosis, treatment issues, participation in treatment, attendance or non-attendance, progress, prognosis, and completion of treatment.

EXPIRATION:

I intend on giving advance consent to information that may come into existence after the date I sign this authorization. This authorization expires on _____, 20____ (i.e., one year from the date it is signed), unless a shorter time is indicated here: _____.

I UNDERSTAND THE FOLLOWING:

- This authorization is voluntary.
- My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form. I may receive a copy of this form.
- I may inspect and copy my protected health information prior to its release and without signing this form.
- This authorization to disclose information may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. To revoke the authorization, I must notify the Provider indicated above or the Mental Health Court Team in writing.
- The Mental Health Court Team is not a health care provider, health plan, or otherwise covered by HIPAA and the information described above may be re-disclosed and no longer protected by HIPAA. However, the Mental Health Court Team is prohibited from re-disclosing mental health, substance abuse, and genetic, or HIV/AIDS-related information under the Federal Substance Abuse Confidentiality Requirements and/or Illinois law.
- If I do not consent, my treatment by any provider will not be affected, but I will not be allowed to participate in the Will County Mental Health Court.

_____ _____

Patient or Personal Representative's Signature Date

If signature is other than by the patient, explain your authority to act for the patient:

_____

I can attest to the identity of the above-named person.

_____ _____

Witness Date