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WILL COUNTY VETERANS AND SERVICEMEMBERS COURT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

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: _____

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.). To the extent any of the following information exists, pursuant to this authorization, I wish to release **HIV/AIDS information**, **developmental disability and/or mental health information** (excluding psychotherapy notes), and **substance abuse information**. I intend on giving advance consent to information that may develop after the date I sign this authorization. Information or records may be released orally, by photocopy, written, electronic, by facsimile or any other means or method.

TO: The Will County Veterans and Servicemembers Court Team at 14 W Jefferson Street, Joliet, Illinois 60432, Attn: Judge Carla Alessio Policandriotes. ***I understand the following agencies and their staff may discuss, disclose, and transfer the information or records among themselves as the Will County Veterans and Servicemembers 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 Veterans and Servicemembers Court Team necessarily includes the following agencies and I intend for the information to be released to any of the following agencies in their capacity as part of the Will County Veterans and Servicemembers Court Team***: The Twelfth Judicial Circuit of Illinois, and/or its staff; the Will County Public Defender's Office, and/or its staff; the Will County State's Attorney's Office, and/or its staff; the Will County Health Department, and/or its staff; the Will County Veterans Assistance Commission and/or its staff, the Will County Probation Department, and/or its staff; the Center for Correctional Concerns, and/or its staff; the Will County Adult Detention Facility, and/or its staff and contractors, including but not limited to Medical.

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PURPOSE OF DISCLOSURE: I submit this request because I want my protected health information to be disclosed to the Will County Veterans and Servicemembers Court Team for the purposes of (1) assessment, (2) coordinating services; (3) monitoring for compliance with a treatment program and my contractual agreement; and (4) discussing the progress, developments, or setbacks of my treatment.

EXPIRATION: This authorization expires one year from the date it is signed.

I UNDERSTAND THE FOLLOWING: • This authorization is voluntary • treatment, payment and/or eligibility for enrollment for 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 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 Veterans and Servicemembers Court Team in writing • The Veterans and Servicemembers 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 Veterans and Servicemembers Court Team is prohibited from re-disclosing mental health, substance abuse, and HIV/AIDS-related information under the Federal Substance Abuse Confidentiality Requirements and/or Illinois law • If I do not consent, my treatment by providers ***not offered through the Will County Veterans and Servicemembers Court*** will not be affected.

_____ _____

Patient / Recipient Date

WITNESS REQUIRED FOR MENTAL HEALTH INFORMATION: The Illinois Mental Health and Developmental Disabilities Confidentiality Act requires any authorization be witnessed by a person who can attest to the identity of the patient / recipient (740 ILCS 110/5(b)).

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

_____ _____

Witness Date