Greater Elgin Family Care Center

CONSENT FOR RELEASE OF INFORMATION

Date: ___/___/_________
Name of Client: ______________________________
Child's Date of Birth: _____/_____/_________
Address: ______________________________ Apt # _____ City ______________,
State, _________ Zip: ______________

I, ____________________________________, grant permission for:
(school) ____________________________________
to release the following information to Greater Elgin Family Care Center:
1. Medical (specify): Immunizations School Health Exams (cfs-600) Diagnoses and Medication
2. Psychiatric/Psychological (specify): any testing evaluations case studies
3. Education (specify): IEP's Report Cards plans
4. Social History/Assessment (specify): behavior reports treatment
5. Other (specify): classroom observations / communications

FOR THE PURPOSE OF:

Casework planning: ___√___
Medical Services: ___√___
Provision of Social Services: ___√___
Other (specify): communication case management and treatment

I understand that any information collected hereunder may not be redisclosed unless the person who consented to this disclosure specifically consents to such redisclosure or the redisclosure is allowed by law.

I understand I have the right to privacy regarding the information collected about my child, family and me in the Behavioral Health Program at Greater Elgin Family Care Center.

I understand that I have the right to inspect, copy or review any information collected about my child, family and me.

This Release of Information is in compliance with the requirement of the Illinois Mental Health and Developmental Disabilities Act.

This consent is valid until ____________________, 20____, which can be terminated at any time. I also understand that I may withdraw this permission in writing at any time except to the extent it has already been acted upon. I understand that my refusal to grant permission or withdrawal of permission will result in a discontinuation of participation in the Behavioral Health Program at Greater Elgin Family Care Center.

Client Signature ______________________________ **Date** __________
(12 years and older)
Parent/Guardian Signature ______________________________ **Date** __________

Witness Signature Date ______________________________ **Date** __________

Greater Elgin Family Care Center

AUTHORIZATION FORM

Date: _____/_____/________
Name of Client: ________________________________
Child's Date of Birth: _____/_____/__________
Address: ________________________________ Apt # ______ City ________________
State ________ Zip: ________

I, ________________________________, grant permission to Greater Elgin Family Care Center's providers, counselors, nursing staff, and/or clerical staff to release any medical information to providers, counselors, nursing staff, and/or clerical staff at my child's school.
Name of School: ________________________________
School's address: ________________________________

____
City State Zip

Specific Information to be Disclosed if Available:

- o The entire medical record excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records.
- o Mental Health Treatment Records
- o Alcoholism Treatment Records/Drug Abuse Treatment Records
- o HIV/Acquired Immune Deficiency Syndrome (AIDS) Records
- o Laboratory Reports/X-rays Reports
- o Other: A copy of my child's immunization records may be sent to his/her school upon request.

Information pertaining to dates of service from ________________ to ________________

This authorization will expire on ____________________ (not valid 3 months after authorization)

I understand that I have the right to inspect and copy the information to be disclosed.

I understand that any information collected hereunder may not be redisclosed unless the person who consented to this disclosure specifically consents to such redisclosure or the redisclosure is allowed by law.

Your treatment will in no way be effected by your refusal to sign this form should you refuse to do so.

The information released may not be protected by federal law and may be released by the recipient.

This authorization is valid until it expires or unless terminated before the expiration date.

I understand that my consent is voluntary and that I may withdraw this consent by written request at any time to Greater Family Care Center except to the extent it has already been acted upon.

Signature: ________________________________ **Date:** _____/_____/________

Relationship to Patient: ____________________

Witness: ________________________________ **Date:** _____/_____/________

Greater Elgin Family Care Center

Authorization For Classroom Observation Form

I ______________________ authorize Greater Elgin Family Care Center to perform a
Name of parent/guardian

classroom observation on ______________________________, _____/_____/_____.
Name of patient Date of birth

I understand that this observation will be performed by a personnel associated with the Behavioral Health Program of Greater Elgin Family Care Center. This classroom observation is conducted under the direction of the provider and coordinator of the Behavioral Health Program. The information gathered at this observation is used to supplement the teacher's questionnaire and parent's rating scale questionnaire.

Parent/Guardian Signature ________________________________ **Date** ____________