ILLINOIS DEPARTMENT OF CORRECTIONS

Authorization for Release of Individual in Custody Medical Health Information

This Authorization may not be used for mental health or substance abuse treatment information (use form DOC 0240)

The Department of Corrections will not condition treatment on this authorization. If authorizing disclosure to persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information. However, genetic testing or HIV/AIDS information disclosed pursuant to this authorization may not be further disclosed except pursuant to authorization.

I hereby authorize _____ to release the following information: (State
Facility
specific medical health information to be disclosed including date(s) or date range)

_____

_____

_____

_____

_____

☐ At Request of Individual in Custody and/or: _____
Purpose of disclosure

from the records of _____ _____
ID# Print Individual in Custody's Name

to: ☐ Self ☐ Authorized Attorney ☐ Health Care Facility ☐ Other: _____

Name: _____
Print Name

Address: _____
Street Address

_____ _____ _____
City State Zip Code

I hereby release and hold harmless, the State of Illinois, the Department of Corrections, and its employees from any liability which may occur as a result of the disclosure or dissemination of the records or information contained therein resulting from the access permitted to the authorized attorney, health care facility, other as specified, or self. Records disclosed may contain confidential medical information including HIV disease information. I understand that I have the right to revoke this authorization at any time prior to disclosure by giving written notice (witnessed by someone who knows my identity) to the prison Facility Privacy Officer.

Expiration: This authorization will expire (complete one):

☐ 45 days from date of signature (_____)

☐ Upon the occurrence of the following event (must relate to the individual or purpose of the authorization):

_____

Signature:

_____ _____ _____
Signature of Individual in Custody or Person Authorized to Consent Relationship Date

Give Individual in Custody a copy if DOC made the request for release.