Little City
Community-Based Clinical Services

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Little City to exchange information of/about: _____
Client Name DOB

TO AND FROM: _____
Provider Name & Address

Type of Information: (CIRCLE)

- Medical (specify):_____
- Mental Health (specify): _____
- Education: _____
- Social History/Assessment (specify): _____
- Financial (specify): _____
- Other (specify): _____

The purpose for requesting/sharing this information is: _____

_____

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether or not the consent is signed by the client or his/her personal representative. HOWEVER, I UNDERSTAND THAT IF I REFUSE TO CONSENT, THE FOLLOWING MAY HAPPEN:

_____

I understand that I may revoke this consent at any time by notifying the Provider of Information listed above in writing, and that the above-named person, authorized to receive this information has the right to inspect and copy the information to be disclosed. I also understand that, even if I do not revoke this consent, the consent will expire one year from the date signed below.

_____
Client's Signature (12 and over) Date

_____
Guardian Signature Date
(Required for all clients under age 18, and for those clients who have a legally appointed guardian)

_____
Staff Witness Date

REDISCLOSURE NOTICE: The information to be disclosed is confidential and is provided only to the party specified in the above consent. The receiving party cannot redisclose the information, except for reports and other information that is required to be released to the court and certain parties to juvenile court proceedings as authorized by the Juvenile Court Act, 705 ILCS 405.