KENDALL COUNTY HEALTH DEPARTMENT

811 W. John Street, Yorkville, IL 60560-9249 630/553-9100 Administration Fax 630/553-9506

______________________ ______________________ Case #______________

Printed Name of **Patient** Previous Names, If Applicable

______________________ ______________________

Date of Birth Social Security #

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

SEND INFORMATION TO/FROM: (place check in box)

Kendall County Health Department Attn: Mental Health
811 W John Street
Yorkville, Illinois 60560
Fax: 630-553-0167

INFORMATION TO BE RELEASED TO: (please be specific)

Patient or Parent/Legal Guardian	Phone:
Address:	Fax:

PURPOSE OF DISCLOSURE: ☐Continued Care ☐Self ☐Specialist ☐Other______________________(must complete)

I authorize the release of:

Medical Records Form ☐last __ year(s) ☐past __ month(s)	☐Yes ☐No	Current Medications	☐Yes ☐No
Psychological Evaluations	☐Yes ☐No	Other (specify)	☐Yes ☐No
Treatment Plans	☐Yes ☐No		

** Please read and initial if you do NOT want certain portions of your records released. I authorize release of all records from Mental Health Cooperative with the exception of the following: ________Psychiatric & Mental Health Records
________HIV/Aids Records
________Substance Abuse (Drug & Alcohol) Records

This authorization is given freely, voluntarily and without coercion.

______________________ ______________ ☐Patient ☐Other______________

Signature of **Patient or Parent/Legal Guardian** Date Specify Relationship

Parental Signature Required for Consumers 18 Years and Younger