

State of Illinois
DEPARTMENT OF REHABILITATION SERVICES
AUTHORIZATION FOR RELEASE OF INFORMATION
BY THE
ILLINOIS DEPARTMENT OF REHABILITATION SERVICES

I authorize the Illinois Department of Rehabilitation Services to release

_____ (state specific nature of information to be disclosed)

about _____

_____ (client's name)

to _____

RECORD COPY SERVICES

_____ (receiving agency/person)

30 N. LA SALLE ST. S-1800, CHICAGO, IL 60602

_____ (address)

for the purpose of _____

This consent is valid until _____

_____ (date)

I understand 1) that I may revoke this consent at any time and 2) that the above-named agency/person authorized to receive this information has the right to inspect and copy the information to be disclosed.

It has been explained to me that if I refuse to consent to this release of information, the following consequences are possible:

(specify, if any) _____

(signature of witness)

(signature of client or legal guardian
of adult)

(date)

(signature of parent or guardian if client
is under age 18.)

(date)

NOTICE TO RECEIVING AGENCY/PERSON: Under the provision of law and regulations, you may not redisclose any of this information unless the Department and the person who consented to this disclosure specifically consent to such redisclosure.

Distribution:

Original - Client's Case File

Copy - Receiving Agency/Person

IL 488-0722 (2/86)