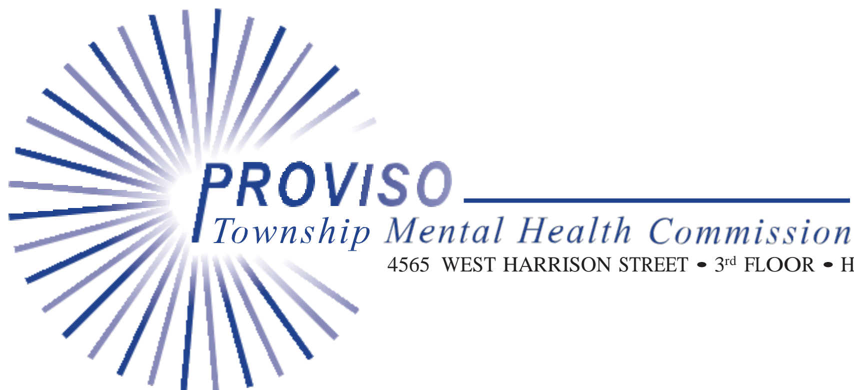

4565 WEST HARRISON STREET • 3rd FLOOR • HILLSIDE, ILLINOIS 60162 • PHONE 708/449.5508 • FAX 708/449.6421

BOARD OF COMMISSIONERS

MICHAEL A. CORRIGAN
PRESIDENT

SHAWNTE RAINES
VICE PRESIDENT

MICHELLE DE LA ROSA
SECRETARY

ERIC R. SAWCHUK
TREASURER

CHLOE PEDERSEN
COMMISSIONER

ORLANDO VELASQUEZ
COMMISSIONER

ANGELA D. WALKER
COMMISSIONER

EXECUTIVE DIRECTOR
JESSE D. ROSAS

COMMISSION ATTORNEY
DEL GALDO LAW GROUP, LLC

Release of Information
AUTHORIZATION FORM
FY 18-19

I,____(**Individuals Name**) hereby authorize _____________________________(**Insert Agency**) to share information with the Proviso Township Mental Health Commission about services delivered during my care for auditing purposes as well as to resolve claim coverage. In addition, the information can be shared with the Network of Care to help identify further services that have been recognized as necessary. Please initial if not interested in the Network of Care ☐

I understand that any personal health information or other information released to the Network of Care may be subject to re-disclosure for the sole purpose of coordinated care. All information collected will continue to be protected by all applicable Federal and State privacy laws for the life of this authorization.

This authorization is valid from the date of my/my representative's signature below and shall expire one year from date of signature**.**

I understand that I have a right to revoke this authorization by providing written notice to ____________________________ (**Insert Agency**) and I understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary.

Name of individual: ____
Signature of individual: _____________________________________
Date:______________________________

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the identified person above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the person's behalf with respect to this authorization form.

Name of Legal Representative: __________________________________
Signature of Legal Representative: _______________________________
Date: ___________________________
Name of Witness: ____
Signature of Witness: __________________________________