CASA KANE COUNTY

Authorization for Release of Information to CASA Kane County – Guardian *Ad Litem*

Full Name: ______________________________ ***Date of Birth:*** ____________________

Address: ______________________________ ***Phone No.:*** ____________________

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Facility / Agency / Person

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Fax Number / Email for Facility / Agency / Person

I authorize and consent to the release information to: **CASA Kane County, 100 South Third Street, Suite 460, Geneva, Illinois 60134; *Court Appointed Guardian Ad Litem for minor child(ren).***

Pursuant to 20 ILCS 301/30-5, 42 C.F.R 2.64, 42 USC 290 dd-2 et seq, 45 C.F.R 160 et seq., 45 C.F.R 164 Parts A & E, 45 C.F.R 164.512, 740 ILCS 110/1 et seq, Illinois Supreme Court Rule 907 and/or 705 ILCS 45/2-18 (4)(e), I authorize the use or disclosure of the health information as described below for the purpose of a legal proceeding occurring in the 16th Judicial Circuit, Kane County, Juvenile Division, State of Illinois.

The information obtained from the above entity will be used by CASA Kane County for the purpose of performing the duties of the Guardian Ad Litem as authorized by the Juvenile Court Act (705 ILCS 405/1) and the 16th Judicial Circuit General Order 14-13.

I agree that the following information should be released. The following items must be checked to be included in the use and/or disclosure of other health information:

DCFS/POS Agency Records

- ☐ Clinical or Counseling Records, Treatment Plans, Psychiatric Diagnosis, Prescribed Medications, Psychological Evaluations
- ☐ Substance Abuse Evaluation, Substance Abuse Treatment Information
- ☐ Medical Records
- ☐ Case Management Records
- ☐ Parenting Records
- ☐ Other: ______________________________

Education/School Records

- ☐ Attendance records, health information, Ability and Achievement Tests, Individual Psychological and special testing, credits earned and courses taken; disciplinary records, grades, educational evaluations, behavior plans, and IEPs.

Medical Records

- ☐ Entire medical record (to include ER records, admission and discharge summaries, dictated reports, and consults, operative and procedure reports, intraoperative, and procedure flow sheets, informed consents, physician orders, progress notes, nurses' notes, flow sheets, medication and transfusion records, test results, labs, pictures, pathology reports, EKGs, fetal monitoring strips, office records, immunization records, growth charts, telemetry strips, radiology and other diagnostic reports, patient instructions).
- ☐ Record abstract (history and physical, progress notes, lab, radiology, operative report, pathology report, consultation report, and diagnostic tests).

☐ Radiology and other diagnostic imaging films, pictures, and/or CD-ROM (X rays, CT scans, MRI, ultrasound, angiogram, diagnostic procedure, etc.).

☐ Approximate Treatment Date(s): ______________________________

Mental Health/Counseling Records

☐ Entire medical record including but not limited to admission and discharge summaries, dictated reports, consults, orders, progress notes, assessments, therapy reports, notes, referrals made and/or received.

☐ Entire treatment record, treatment plan(s), medication management, medication history, labs, alcohol and drug screening results, impatient/Detox discharge instructions/summaries, assessments, screenings, diagnosis, record of attendance in program and abstract of record.

☐ Complete Psychiatric Evaluations, Psychological Evaluations, Mental Health Assessments/Evaluations.

Substance Abuse Records

☐ Treatment records, treatment plan(s), medication management, medication history, labs, alcohol and drug screening results, impatient/Detox discharge instructions/summaries, assessments, screenings, diagnosis, record of attendance in program and abstract of record.

☐ Other (Specify): ______________________________

For the date range of: ______________________________

I authorize verbal, written, telephonic, faxed or electronic transmission as forms in which the information shall be released.

I authorize the release of documents and information prior to the date signed as well as any documents generated or information that may occur in the course of my treatment, now and in the future up to the expiration date of the consent and release.

I understand that I may revoke this authorization at any time by giving written notice to CASA Kane County. A revocation will not affect information previously disclosed.

I understand the disclosure of health information is voluntary. I can refuse to sign this authorization. I understand if the person or entity receiving the information is not a healthcare provider or health plan covered by federal HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

I permit the Guardian Ad Litem to re-disclose this information to the Court, counsel, and all other parties in these proceedings pursuant to the Health Insurance Portability and Accountability Act of 1996, Illinois Mental Health and Developmental Disabilities Confidentiality Act and Federal Confidentiality Rules, including 42 CFR Part 2 and 705 ILCS 405.

Expiration date (not to exceed 12 months): ______________________________

I acknowledge that I have received a copy of this authorization.

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Signature of Patient/Client or Patient/ Client's Legal Representative

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Print Patient/Client Name

____

Date

Prepared by:
CASA Kane County
Guardian Ad Litem
100 South Third Street, Suite 460
Geneva, Illinois 60134
(630) 232-4484