



## Authorization for Release of Information

### Applicant/Participant Information

Name:		Phone:	Email:
Social Security or ID Number:	Date of Birth: MM / DD / YYYY		Illinois County of Residence:
Address:			
City:		State:	Zip:

**Requestor Contact Information** *If you are not the Applicant/Participant, attach the appropriate legal documentation assigning you as the Applicant/Participant's Legal Representative.*

Name:		Phone:	Email:
Address (if different from Applicant/Participant above):			
Relationship to Participant: <input type="checkbox"/> Self <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Guardian <input type="checkbox"/> Other (explain):			

**Information Requested:** List the information you are requesting (e.g. specific type of information, specific time frames, specific provider, etc.)

**Purpose of Authorization:** List why you are authorizing the release of this information (e.g.: proof of services, possible litigation, etc.)

### Send the Information to:

<input type="checkbox"/> Applicant/Participant (at address above)	<input type="checkbox"/> Requestor (at address above)	<input type="checkbox"/> Name and Address of Person, Organization or Agency:
Send as: <input type="checkbox"/> Via Secure Email:		<input type="checkbox"/> Paper Documents via USPS

**Release Authorization:** I, the Applicant/Participant or the Legal Representative listed above, authorize the Illinois Department on Aging (IDoA) to release the requested information to the individual or entity listed for the purposes described. I understand that this authorization expires one year from the Date of Authorization and that I may revoke this authorization at any time by sending a written notification to IDoA at an address listed below. If I revoke the Authorization, it will not affect any information released before the revocation was received by IDoA. I also understand that the person receiving this information may disclose the information which may affect my protection under federal or state law.

Printed Name	Signature	Date of Authorization
--------------	-----------	-----------------------

Send this form and the required Legal Representative supporting documentation to: **IDoA Office of General Counsel, One Natural Resources Way, Springfield, IL, 62702-1271** or email to: [Aging.Subpoenas.Authorizations@illinois.gov](mailto:Aging.Subpoenas.Authorizations@illinois.gov)