CONSENT AND RELEASE FOR DISCLOSURE OF MEDICAL INFORMATION

I have filed a charge of discrimination with the Illinois Department of Human Rights (IDHR) related to my following medical condition(s).

IDHR Charge Number: _____

Medical Condition(s): _____

Relevant Date(s): _____

I hereby permit the Health Care/Social Service Professional identified below, or other authorized medical professional at the same facility, to complete the Verification of Disability Form and return the completed form to the IDHR, and to answer any questions IDHR my have regarding the information contained in this form. Please send all correspondence to the attention of the investigator assigned to my case, or if no investigator is listed below, to the Unassigned Case Unit.

Health Care or Social Service Professional: _____

Address: _____

Telephone No.: _____

(Note to Complainant: if an investigator has not yet been assigned to your case, or if you do not know the name of your investigator, please leave the following blank.)

Investigator: _____

I understand that:

- IDHR is requesting this information for the purpose of investigating my charge of discrimination
- The completed Verification of Disability Form, once returned to IDHR, will become part of IDHR's investigation file and may be subject to disclosure through subpoena, the Illinois Freedom of Information Act, or any other lawful means to the parties, the general public, or other governmental agencies, including the U.S. Equal Employment Opportunity Commission, local human rights agencies or commissions, or the Office of Executive Inspector General for the Agencies of the Illinois Governor.
- In lieu of signing this Consent and Release for Disclosure of Medical Information, I may submit information from other sources regarding my identified condition, such as my testimony regarding my condition, determinations of disability from the U.S. Social Security Administration, Family and Medical Leave Act forms, or other similar documentation to show that my condition constitutes a disability within the meaning of the Illinois Human Rights Act.
- I have the right to decline to sign this consent and release, and if I do so, IDHR will make a determination on my charge with other information and evidence obtained during the investigation, including any other information I submit.
- This consent form will expire one (1) year from the date of my signature below and may not be used after that date.

_____ _____

Signature of Patient (Complainant) or other person legally entitled to give consent — Date

_____ _____

Patient's Name (Complainant's Name - Printed) — Patient's Date of Birth

_____ _____

Address — City, State, ZIP Code

_____ _____

Witness Signature (Person who can attest to the identity of the Patient or other person entitled to give consent) — Date

_____

Witnessed by (Name - Printed)

ILLINOIS DEPARTMENT OF
Human Rights

VERIFICATION OF DISABILITY (EMPLOYMENT)

Dear Health Care or Social Service Professional:

Your patient (Complainant) has filed a charge with the Illinois Department of Human Rights (IDHR) alleging that s/he has experienced unlawful discrimination because of the condition identified on the attached Consent and Release for Disclosure of Medical Information Form. Your patient has identified you as a source of information regarding the condition and has authorized IDHR to obtain this information from you by signing the attached Consent Form. In order to help IDHR determine whether the Complainant's condition qualifies as a disability under the provisions of the Illinois Human Rights Act, please answer the following questions concerning **only** the condition or conditions during the relevant dates identified on the Consent Form.

Charge Number: _____

Complainant: _____

Condition(s) Identified on the Consent and Release for Disclosure of Medical Information form:

_____

Relevant Dates Identified on the Consent and Release for Disclosure of Medical Information form:

_____

Please Note: **We ask your cooperation in providing the following information and returning it to IDHR. Your prompt return of this information will help to ensure timely investigation of the Complainant's discrimination claim. IDHR is not responsible for any fees or costs associated with completing this form. If there are fees for a file search and/or copying, IDHR requests that these fees be waived. If you decline to waive the fees or costs associated with completing this form, please immediately notify IDHR. Please direct all correspondence and inquiries to the Investigator identified on the Consent and Release for Disclosure of Medical Information form. If no Investigator is identified, please send all correspondence and inquiries care of the Unassigned Case Unit.**

Name of Investigator Identified on Consent Form (If any): _____

1. Can you confirm that Complainant has/had the condition on the relevant dates identified?

   ☐ Yes ☐ No

2. Is Complainant's condition a physical, mental, or emotional impairment?

   ☐ Yes ☐ No

3. Is Complainant's condition **minor**?

A minor condition is a condition which is trivial or insubstantial, and is not a disability under the Illinois Human Rights Act. In determining whether a condition is minor, please note the following:

- If the individual is using mitigating measures to address the condition, such as a walking cane, prosthetic, hearing aid, service animal, or medication, you should assess the condition in its unmitigated state.
- If the individual's condition is episodic or in remission, you should assess the condition in its active state.

Examples of minor conditions include conditions which are expected to fully heal without any complications, or non-life threatening conditions which can be successfully treated by ordinary medications or minimally invasive surgical procedures.

☐ Yes ☐ No

If "Yes", please explain why the condition is minor:

4. Is Complainant's condition permanent?

☐ Yes ☐ No

If "No", please describe the length of time Complainant's condition is expected to last (be as specific as possible):

5. During the last two years, did you place any restrictions on Complainant related to the condition?

☐ Yes ☐ No

If "Yes", for each restriction please identify (a) the restriction, (b) the date the restriction was imposed, and (c) the duration of the restriction:

Health Care or Social Service Professional - Please provide the information requested below:

Signature	Address
Printed Name	City, State, ZIP Code
Date Form Completed	Telephone Number

Please return this completed form to:

Illinois Department of Human Rights
100 W Randolph St. Ste. 10-100
Chicago, IL 60601

Please send the form C/O the Investigator named on the Consent form, or if no Investigator is named, C/O the Unassigned Case Unit