ILLINOIS DEPARTMENT OF CORRECTIONS

Authorization for Release of Offender Mental Health or Substance Abuse Treatment Information

This Authorization may not be used for medical health information (use form DOC 0241)

The Department of Corrections will not condition treatment on this authorization. Mental health information disclosed pursuant to this authorization may not be further disclosed except pursuant to authorization from the offender or offender's representative. If this authorization is for psychotherapy notes, it must not be used as an authorization for any other type of protected health information.

I hereby authorize _____ to release
Facility

Section A: Mental Health Information (State specific Mental Health information to be disclosed including date(s) or date range) **:**

_____

_____

_____

_____

_____

Section B: Substance Abuse Treatment Information (as indicated below) **:**

If Substance Abuse Treatment records are being authorized, initial all relevant areas below (including date(s) or date range):

☐ Diagnosis _____ ☐ Toxicological Reports/Drug Screens _____
☐ Evaluation/Assessment _____ ☐ Medication Management Information _____
☐ Treatment Plan _____ ☐ Attendance in Treatment _____
☐ Summary of Treatment Services _____ ☐ Treatment Progress Report _____
☐ Continuing Care Plan _____ ☐ Educational Information _____
☐ Other (specify): _____

☐ At Request of Offender and/or: _____
Purpose of disclosure

from the records of _____ _____
ID# Print Offender's Name

to: ☐ Self ☐ Authorized Attorney ☐ Health Care Facility ☐ Other: _____

Name: _____
Print Name

Address: _____ _____ _____ _____
Street Address City State Zip Code

I hereby release and hold harmless, the State of Illinois, the Department of Corrections, and its employees from any liability which may occur as a result of the disclosure or dissemination of the records or information contained therein resulting from the access permitted to the authorized attorney, health care facility, other as specified, or self. I understand that I have the right to revoke this authorization at any time prior to disclosure by giving written notice (witnessed by someone who knows my identity) to the prison Facility Privacy Officer.

Expiration: This authorization will expire (complete one):

☐ 45 days from date of signature

☐ Upon the occurrence of the following event (must relate to the individual or purpose of the authorization):

_____

Signature:

_____ _____ _____
Signature of Offender or Person Authorized to Consent Relationship Date

Witness:

_____ _____
Print Name Title

_____ _____
Signature Date

Give Offender a copy if DOC made the request for release.

Distribution: Offender's Medical File

DOC 0240 (Rev. 01/2005)

Printed on Recycled Paper