CFS 440-7
Rev 3/2005

State of Illinois
Department of Children and Family Services

CONSENT FOR DISCLOSURE OF INFORMATION

SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT

I, _____, whose birth date is _____, and whose
(Name of individual) (Birth date)

address is _____ and

whose Social Security Number is _____, hereby authorize:
(Social Security Number)

The Department of Human Services and/or _____
(AOD service program or agency name)

AND

The Department of Children and Family Services and/or _____
(Agency name)

to provide between each other the following information (*Client and/or guardian must initial the applicable information to be disclosed*):

_____Identifying information, including legal name, address, date of birth and SSN

_____Information about substance abuse history

_____Information about treatment attendance, placement, and progress

_____Information about discharge/continuing care plan or discharge status

_____Information on urinalysis results

_____Copy of client's portion of the Individualized Client Service Plan and Social History

_____Information about attendance at assessment interview

_____Notification of upcoming court hearings, case reviews, etc. to allow preparation of status reports

_____Information about parent-child interactions observed during the treatment process

_____Information on return home of children

_____Re-disclosure of information on substance abuse history and treatment progress to the court and certain parties to juvenile court proceedings as authorized by the Juvenile Court Act and as ordered by the Court.

I understand that this exchange of information is necessary to complete my referral for needed services and for obtaining updates regarding my attendance at and progress in treatment. I understand that I may revoke this consent at any time, except to the extent that the disclosure agreed to has been acted on.

I may revoke this consent, in writing, at any time by sending written notification to my DCFS or POS caseworker and the substance abuse treatment provider at

(DCFS/POS Caseworker Name)	**AND**	(AOD Agency Contact Person Name)
(DCFS/POS Caseworker Address)		(AOD Agency Address)

I understand that I have the right to inspect and copy the information to be disclosed.

If not previously revoked, this consent will terminate when any of the following conditions have been met: 1 year from the date of this signature or 30 days following discharge from treatment (whichever is later) or other date, event, or condition (as specified): _____. Redisclosure of the personal health information of the client referenced above may not occur without prior written consent, except as expressly provided for in this Consent.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether or not the consent is signed by the client or his/her personal representative. I further understand that the substance abuse treatment agency will not condition my treatment on whether I give consent for the requested disclosure. However, it has been explained to me that if I refuse to consent to this disclosure, the Department (or private child welfare agency, where applicable) or court entity cannot receive information regarding my progress that may affect the child welfare decisions made regarding my family's case.

☐ Check here if above-named individual refuses to sign the consent.

Signature of Individual 12 years and Older	Date

I,_____, the parent or the legal guardian or custodian appointed pursuant to 705 ILCS 405/2-11 or 705 ILCS 405/2-27, am authorized to act on behalf of the individual minor, _____, I hereby consent to this limited disclosure under the terms stated above. The legal guardian or parent is the legal representative of the unemancipated minor, pursuant to HIPAA, 45 CFR 164.502(g), unless otherwise required by law.

Signature of Parent, Guardian, or Authorized Agent	Date
Signature of Witness	Date

NOTICE TO RECEIVING AGENCY OR PERSON: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general consent for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.