



## AUTHORIZATION TO DISCLOSE APPLICATION ASSISTANCE INFORMATION TO AUTHORIZED INDIVIDUALS

**Please return this form to:**  
 Oak Forest Health Center  
 Application Assistance Processing Ctr.  
 15900 S. Cicero Avenue  
 Building H, Room H-2400  
 Oak Forest, IL 60452  
 Email: [Appassistor@cookcountyhhs.org](mailto:Appassistor@cookcountyhhs.org)  
 Fax: (708) 633-6949

**Instructions:** Please complete this form in its entirety. Signing this form will only authorize Call Center Representatives (CSRs) to disclose PHI over the phone to the authorized individuals indicated below.

Client Last Name	Client First Name	Client Middle Name	
Date of Birth		Today's Date	
Address	City	State	Zip
Phone			
<b>INDIVIDUALS AUTHORIZED.</b> I authorize Cook County Health & Hospitals System to share my protected health information to the following individual(s) for the purposes of assisting with my application to financial assistance program application or reapplication.			
Individual #1 Name	Relation to Client		Phone
Individual #2 Name	Relation to Client		Phone
Individual #3 Name	Relation to Client		Phone
<b>INFORMATION REQUESTED.</b> I authorize Cook County Health & Hospitals System to share the following information to the individuals authorized above during the term of this Authorization. <b>Check all that apply.</b> <input type="checkbox"/> Information about eligibility, the status of my application or re-application <input type="checkbox"/> Other (please specify): _____			
<b>TERM.</b> Unless a box below is checked, this Authorization will expire <u>one year</u> past date of application assistance. <input type="checkbox"/> From the date of this Authorization until: _____ <input type="checkbox"/> Other (please specify): _____			
<b>VOICEMAIL MESSAGES.</b> <input type="checkbox"/> I authorize Cook County Health & Hospitals System to leave voicemail messages with the individuals listed above regarding applying for financial assistance programs or reapplying for coverage.			
<ul style="list-style-type: none"> <li>• I understand that I may revoke this authorization at any time by notifying CCHHS in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by CCHHS before receiving my revocation.</li> <li>• I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.</li> <li>• I understand that I have the right to inspect or copy any information shared under this authorization.</li> <li>• I understand that once my information is disclosed to the recipient CCHHS cannot guarantee that the recipient will not redisclose the information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws. I have read and understand the terms of this Authorization and I have had a chance to ask questions about the use and disclosure of my health information.</li> <li>• I authorize CCHHS to use or disclose my health information in the manner described in this Authorization.</li> </ul>			
<b>SIGNATURE</b>			
Signature of Individual		Date	
<b>FOR PERSONAL REPRESENTATIVES OF THE CLIENT</b>			
Name of Personal Representative:		Relation to Client:	
<i>I hereby certify that I have the legal authority under applicable law to make this request on behalf of the Client identified above.</i>			
Signature of Personal Representative		Date	