COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

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
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

INDIVIDUALS AUTHORIZED. 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**

INFORMATION REQUESTED. I authorize Cook County Health & Hospitals System to share the following information to the individuals authorized above during the term of this Authorization. **Check all that apply.**

☐ Information about eligibility, the status of my application or re-application
☐ Other (please specify): _____

TERM. Unless a box below is checked, this Authorization will expire one year past date of application assistance.

☐ From the date of this Authorization until: _____
☐ Other (please specify): _____

VOICEMAIL MESSAGES.

☐ 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.

- 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.
- 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.
- I understand that I have the right to inspect or copy any information shared under this authorization.
- 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.
- I authorize CCHHS to use or disclose my health information in the manner described in this Authorization.

SIGNATURE

Signature of Individual	**Date**

FOR PERSONAL REPRESENTATIVES OF THE CLIENT

Name of Personal Representative:		Relation to Client:	

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the Client identified above.

Signature of Personal Representative	**Date**