



**Release of Information  
AUTHORIZATION FORM  
FY 22-23**

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Del Galdo Law Group, LLC

I, \_\_\_\_\_ (Individuals Name)  
hereby authorize \_\_\_\_\_ (Insert Agency) to share  
information with the Proviso Township Mental Health Commission about  
services delivered during my care for auditing purposes as well as to resolve  
claim coverage. All information collected will continue to be protected by all  
applicable Federal and State privacy laws for the life of this authorization.

This authorization is valid from the date of my/my representative's signature  
below and shall expire June 30, 2023.

I understand that I have a right to revoke this authorization by providing  
written notice to \_\_\_\_\_ (Insert Agency) and I  
understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary.

**Name of individual:** \_\_\_\_\_

**Signature of individual:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**If applicable, Legal Representatives sign below:**

*By signing this form, I represent that I am the legal representative of the  
identified person above and will provide written proof (e.g., Power of  
Attorney, living will, guardianship papers, etc.) that I am legally authorized  
to act on the person's behalf with respect to this authorization form.*

**Name of Legal Representative:** \_\_\_\_\_

**Signature of Legal Representative:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Name of Witness:** \_\_\_\_\_

**Signature of Witness:** \_\_\_\_\_

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