



Release of Information
AUTHORIZATION FORM
FY 23-24

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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, 2024.

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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