PROVISO TOWNSHIP | MENTAL HEALTH COMMISSION

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Release of Information
AUTHORIZATION FORM
FY 25-26

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, 2026**.**

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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