Illinois Department of Human Services
Illinois Center for Rehabilitation and Education – Roosevelt
1950 West Roosevelt Road ~ Chicago, IL 60608
FAX: 312-433-3254/Attention: Susan Devitt

Release of Information-Medical

Date:

REGARDING:

Name:	Date of Birth:	
Address:	City:	State/Zip Code:
Name of Parent/Guardian:		

I authorize the Illinois Center for Rehabilitation and Education – Roosevelt (ICRE-R) to release/obtain the following information to/from:

Name:	Phone:
Address:	FAX:
City, State:	Zip Code:

Specific information to be disclosed:

☐ Psychological reports	☐ IEP
☑ Medical including surgical summaries	☐ Multidisciplinary staffing reports
☑ Immunization records	☐ Physical and occupational therapy reports
☐ Audiological reports	☐ Diagnostic and prescriptive reports from the
☐ Vision reports	☐ Educational Clinical Service Department
☐ Speech/communication/language reports	☐ Vocational evaluation reports
☐ Social history	☑ Free of Communicable Disease Letter
☐ School reports	☑ Physical/Certificate of Health

This information is needed for the following purpose: (a) to update or complete student records, (b) for assessment and evaluation of potential applicants (c) other: _____.
This consent for disclosure is valid until: ***one year from date of signature***_____.
I understand 1) that I may revoke this consent at any time; 2) that both I and the above named agency/person authorized to receive this information have the right to inspect and copy the information to be disclosed; 3) that I may challenge the contents as provided by Section 7 of the Illinois School Student Records Act; and 4) that I may limit my consent to designated records or designated portions of the information herein. It has been explained to me that if I refuse to consent to this release of information, the following consequences are possible:

_____

_____ _____ _____
(Signature of Witness) (Signature of parent/guardian if client/student is under the age of 18) (Date)

_____ _____
(Signature of client/student if 18 or older or legal guardian of an adult) (Date)

NOTICE TO RECEIVING AGENCY/PERSON: Under the provisions of law and regulations, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure.
This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under the Illinois School Student Records Act (IL Rev. Stat. 1965.ch. 122. Para. 50-1 et.seq.). Disclosure of this information is VOLUNTARY; however failure to comply may result in this form not being processed. This form has been approved by the State Forms Management Center.
488-1700