Prenatal Social Service Release of Information for Health Department

PACT for West Central IL, Central Office 2090 HWY 24, Camp Point, IL 62320 (217-773-3903, fax # 217-773-3906)

Expectant Mom Name _____ DOB ___/___/___ Area # _____
Expected Delivery Date ___/___/___
Street Address _____
City, State, Zip _____
Phone # _____

I hereby authorize Parent & Child Together (PACT) for West Central Illinois to release/receive the following confidential information regarding the above named individual to/from:

Health Department _____
Street Address_____
City, State, Zip_____
Phone # _____ Fax # _____

For the purpose of: Informing the named Health Department that a PACT Expectant Mom has enrolled in our program and will be needing a Postpartum Home Visit within 2 weeks of delivery. This release may also be used to set up such visit after mom has delivered.

I understand that I may revoke this authorization by giving written notice. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by the provider in reliance before I revoked it. I understand that the information used or disclosed may be subject to re-disclosure by the agency receiving it and is no longer protected by the federal privacy regulations. However, PACT does not re-disclose information unless a written authorization requests it. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits from the provider releasing information (listed above). I understand that this authorization is valid one year from the date signed, or until I revoke it in writing to the agency releasing information.

_____ _____
(Expectant Mom Signature) (Date)

Email to Health Coordinator after intake & keep in file H 5/22