

Name:

Date of Birth:

I, the above named, give permission for staff members of Promise Healthcare to disclose and obtain information related to care coordination, housing assistance, benefits eligibility, social services, and case management services as authorized by the patient:

(Please initial by the agencies you approve of)

- Regional Planning Commission

Housing Authority of Champaign County

Champaign-Urbana Tenant Union

Rosecrance

PACE: Center for Independent Living

First Followers

Salvation Army

Cunningham Children's Home

City of Champaign Township

Cunningham Township

Champaign County Health Care Consumers

Land of Lincoln Legal Aid

STRIDES

Family Services

Community Service Center of Northern Champaign County
- Daily Bread Soup Kitchen

Salt and Light

Phoenix House/ CU at Home

Habitat for Humanity

Department of Human Services

Courage Connection

Champaign Urbana Public Health Department

OSF Hospital

Empty Tomb

WIN Recovery

Carle Health

Social Security Administration

Jesus is the Way Ministries

Other:

Information Authorized for Sharing (Initial all that apply):

- Medical Information

Reproductive Health Information

Mental Health Information

Substance Use Disorder Treatment Information

By signing this release form , I authorize Promise Healthcare to obtain, use, and share the information indicated above with approved community partners for the purpose of care coordination, referrals, and access to services. I understand that I may revoke this authorization at any time by providing written notice to Promise Healthcare.

Signature:

Date:

This authorization remains valid while the patient is receiving services at Promise Healthcare unless an earlier expiration date is specified or the authorization is revoked in writing. If multiple versions of this form are completed, only the most recent signed version is valid. If the patient is a minor at the time of signature, this authorization expires when the patient reaches the age of majority (18yo) or emancipated.