Waukegan Township

MARC L. JONES, SUPERVISOR

Case # _____

AGENCY RELEASE OF INFORMATION

Supervisor's Office
149 South Genesee Street
Waukegan, IL 60085
P. 847-244-4900
F. 847-244-5185

Eddie Washington Center
424 South Avenue
Waukegan, IL 60085
P. 847-244-0805
F. 847-244-2048

Staben House
149 South Genesee Street
Waukegan, IL 60085
P. 847-244-9944
F. 847-625-0437

Park Place
414 South Lewis Ave
Waukegan, IL 60085
P. 847-244-9242
F. 847-244-9258

Home Sweet Home
36117 Green Place
Waukegan, IL 60087
P. 847-599-2932
F. 847-244-2048

Road & Bridge Department
36117 Green Place
Waukegan, IL 60087
P. 847-662.7208
F. 847-662.1631

I, _____, __ __ __-__ __-__ __ __ __ authorize the disclosure of information regarding my status, including disability determinations, if any, with the below named agency, to the Waukegan Township or any properly identified representative of said Agency, 149 S. Genesee St., Waukegan, IL 60085.

This form states, that this is a two-way release of information between the persons of organizations listed below and Waukegan Township.

Agency/Address:

Dept of Human Services	**Dept. of Social Security**	**Dept of Employment**
2000 N. Lewis Ave	**1930 N. Lewis Ave**	**1 N. Genesee Street #100**
Waukegan, IL 60087	**Waukegan, IL 60085**	**Waukegan, IL 60085**

This consent is valid until _____/__ __/20__ __.

I understand that I may revoke this consent at any time except to the extent that information has already been released based upon consent, and that the above named person authorized to receive this information has the right to inspect and copy the information to be disclosed.

I understand that the consequences of refusal to consent are that I will be deemed ineligible to receive services, monetary or otherwise, from Waukegan Township.

_____ _____
Client's Signature Date

_____ _____
Witness Date

Note To Receiving Agency/Person: Under the provisions of the Illinois Medical Health and Developmental Disabilities Act, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. I understand that released information may not be released to any other person or organization without my written consent. (This is in compliance with the Federal Regulations governing the Confidentiality of Alcohol and Drug Abuse client records, as noted in 42 CFR, part 23 [a]).

IN ORDER TO ENSURE CONFIDENTIALITY, PLEASE INCLUDE THE REQUESTER'S NAME ON THE MAILING ENVELOPE.