



Authorization for Release of Ombudsman Records

Resident/Participant Information

Name:	Phone:	Email:
Date of Birth: MM / DD / YYYY	Illinois County of Residence:	
Address:		
City:	State:	Zip:

Requestor Contact Information *If you are not the Resident/Participant, attach the appropriate legal documentation assigning you as the Resident/Participant's Legal Representative.*

Name:	Phone:	Email:
Address (if different from Resident/Participant above):		
Relationship to Resident/Participant: <input type="checkbox"/> Self <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Guardian <input type="checkbox"/> Other (explain):		

Information Requested: List the information you are requesting (e.g. specific type of information, specific time frames, specific provider, etc.)

Purpose of Authorization: List why you are authorizing the release of this information (e.g.: proof of services, possible litigation, etc.)

Send the Ombudsman Records to:

<input type="checkbox"/> Resident/Participant (at address above)	<input type="checkbox"/> Requestor (at address above)	<input type="checkbox"/> Name and Address of Person, Organization or Agency:
Send as:	<input type="checkbox"/> Via Secure Email to: <input type="checkbox"/> Paper Documents via USPS	

Release Authorization: I, the Resident/Participant, the Legal Representative or Ombudsman representative listed above, authorize the Illinois State Long-Term Care Ombudsman Program (SLTCOP) to release the requested information to the individual or entity listed for the purposes described. I understand that this authorization expires one year from the Date of Authorization and that I may revoke this authorization at any time by sending a written notification to SLTCOP at an address listed below. If I revoke the Authorization, it will not affect any information released before the revocation was received by SLTCOP. I also understand that the person receiving this information may disclose the information which may affect my protection under federal or state law.

Printed Name

Signature

Date of Authorization

Send this form and the required Legal Representative supporting documentation to the State Long-Term Care Ombudsman Program (SLTCOP) One Natural Resources Way, Springfield, IL, 62702-1271 or email to: Aging.SLTCOPProgram@illinois.gov