Clara Deenis Trust
Release of Information Form

I, (parent/guardian)________________________________, hereby authorize the Illinois Valley Center for Independent Living to receive written and/or verbal information from or release written and/or verbal information to the below list of entities to exchange client information, eligibility information, and all information concerning funds requested from the Clara Deenis Trust funds to determine eligibility for

(Child)____ DOB ______________________

____
Address City State Zip

IVCIL is authorized to exchange information with the following list of entities:

To include but not limited to: Agencies, Medicaid, Medical Insurance, Doctor, Psychologist, Vendors

Name of Agency & Contact	Phone	Name of Agency & Contact	Phone
DHS		DSCC	
DRS		TCOC	
Dr.		Dr.	
Hospital		Insurance	
Township		Salvation Army	

I understand that I have the right to inspect and copy the above information prior to its disclosure. I also understand that I may revoke this consent at any time except to the extent that action based upon it has already been taken. In the event that express revocation is not made, this authorization will automatically expire on ______/_______/______.

This authorization and request are fully understood and made voluntarily on my part. Lack of consent may have an impact on the ability of the Illinois Valley Center for Independent Living to provide services.

______________________________ ______________________________ _______/_______/______
Parent/Guardian Signature Printed Name Date

Witness____Date___________________

(NOTE: No financial assistance will be considered until both the application and this release of information, along with the supplemental backup documentation requested, are received by IVCIL.)