



Pat Quinn, Governor
Rocco J. Claps, Director

CONSENT FOR INSPECTION AND COPYING OF MEDICAL INFORMATION

Date: _____ Charge No. _____

To Whom It May Concern:

I have filed the above-captioned charge of unlawful discrimination in real estate transactions in which my physical or mental condition is an issue. I hereby authorize that all medical information pertaining to my medical condition(s) of _____ including any information about reasonable accommodations I might require to fully enjoy my housing accommodation, in possession of:

Medical Authority or Facility/Physician/Respondent

may be released to the Department of Human Rights, 100 West Randolph, Suite 10-100, Chicago, IL 60601 to the attention of :

Investigator Name:
Investigator Telephone Number: 312-814-

If there is a fee for a file search and/or copying, I am responsible for the charges, and not the Department of Human Rights.

Further, I understand and consent that this information will become part of the Department's investigation file and as such may be reviewed by personnel of the Department, as well as the Illinois Human Rights Commission, the United States Equal Employment Opportunity Commission, the United States Department of Housing and Urban Development, the Respondent and pursuant to subpoena and/or court order.

I understand that I have the right to revoke this Consent at any time in writing, signed by me, with my signature witnessed by a person who can attest to my identity. I understand that no written revocation of this Consent can prevent disclosure of records and communications until the person otherwise authorized to disclose records and communications receives it.

I further understand that if I refuse to consent to the disclosure of this medical information, my charge may be dismissed.

This Consent Form shall expire on _____.

Signature of Patient or other person entitled to give consent: _____ Date: _____

Patient's Name:
Patient's Date of Birth:
Address:
City, State, Zip Code:

Witnessed by _____, who can attest to the identity of the Patient or other person entitled to give consent.

Witness signature: _____
Form 10Hsg 10/07