Maple Street Clinic
109 E. Maple, Gillespie, IL 62033
217-839-1526 ~ Medical/Behavioral
217-839-1538 ~ Medical/Behavioral (fax)
217-839-4110 ~ Dental
217-839-4105 ~ Dental (fax)

Macoupin County
Public Health Department

Morgan Street Clinic
1115 Morgan St., Carlinville, IL 62626
Medical ~ 217-854-3692
Dental ~ 217-854-6823
Medical & Dental (fax) ~ 217-930-2293

Administrative Office ~ 205 Oakland Ave ~ Carlinville, IL ~ 217-854-3223 (p) ~ 217-854-3225 (fax)
St. Francis Way Clinic ~ 805 St. Francis Way ~ Litchfield, IL 62056 ~ 217-250-2380 (p) ~ 217-250-2385 (fax)
Columbian Blvd. Dental Clinic ~ 125 W. Columbian Blvd. South ~ Litchfield, IL 62056 ~ 217-250-2360 (p) ~ 217-250-2365 (fax)

Authorization to Release/Obtain Confidential Healthcare Information

Please print clearly when completing this form.

Patient name: _____ Date of Birth: _____/_____/_____

Address: _____
Street City State Zip

Release/Send Information **FROM**:	Release/Send Information **TO**:
☐ **MCPHD** Includes all Macoupin County Public Health Department Clinics and Locations ☐ Other – Specify organization, department, or individual (complete each line below) _____ Street _____ City _____ State _____ ZIP Code _____ Ph: _____ Fax/ Email: _____	☐ **MCPHD** – Dept/Clinic _____ Fax: _____ ☐ Other – Specify organization, department, or individual (complete each line below) _____ Street _____ City _____ State _____ ZIP Code _____ Ph: _____ Fax/Email: _____

☐ By checking this box, I allow the ongoing information exchange between the above parties until this authorization expires or is revoked.

☐ By checking this box, I also authorize the release of records for future visits after the date of my signature until this authorization expires or is revoked.

For the purpose of:

- ☐ Coordinate medical, psychological, and dental services
- ☐ Transfer of care
- ☐ Other: (specify) _____
- ☐ Legal proceedings
- ☐ Patient request

This request and authorization applies to:

- ☐ All healthcare information and records
- ☐ All dental information and records
- ☐ Date(s) of treatment from: _____ to _____ or a specific date: _____
- ☐ Other: (specify) _____
- ☐ All dental information, records and x-rays
- ☐ Immunizations, lead, and hemoglobin results

This authorization will expire in 1 year from date of signature unless another date is specified here: _____

PLEASE INDICATE BY INITIALING ***MUST BE INITITIALED BY PATIENT IF AGE 12 YEARS OR OLDER***

_____ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above must obtain my specific written permission before disclosing this information to anyone.

_____ I authorize the release of any record regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I authorize the use or disclosure of my protected health information to Requestor, either verbally, in writing, and/or electronically, as described above.

I acknowledge that I may revoke this authorization in writing at any time, except where action has already been taken in reliance on it, and that revocation instructions are available in the Macoupin County Public Health Department Notice of Privacy Practices, which I may request at any time.

I acknowledge that once my health information is disclosed pursuant to this authorization, the recipient may redisclose it. Such redisclosure may not be subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA).

I acknowledge that treatment, payment, enrollment, or eligibility may not be conditioned upon my signing of this Authorization.

_____ _____/_____/_____
Signature of Patient if Age 12 Years or Older — Date Signed

_____ _____/_____/_____
Signature of Parent, Guardian, or Personal Representative — Date Signed

_____ _____
Printed Name of Authorized Signer — Relationship to Patient

_____ _____/_____/_____
Witness Signature — Date Signed

For additional information, please contact the Macoupin County Public Health Department Medical Records Department directly at (217)839-7799. Requests can also be emailed to medicalrecords@mcphd.net.