Maple Street Clinic
109 E. Maple, Gillespie, IL 62033
217-839-1526 – Medical/Behavioral
217-839-1538 - FAX
217-839-4110 – Dental

Macoupin County Public Health Department

Morgan Street Clinic
1115 Morgan Street, Carlinville, IL 62626
217-854-3692 – Medical/Behavioral
217-854-930-2293 – FAX
217-854-6823 – Dental

Authorization to Release/Obtain Confidential Healthcare Information

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

Address: _____
(Street) (City) (State) (Zip)

I request and authorize _____ _____ _____
(Doctor or facility releasing records) (Phone) (Fax)

to release healthcare information regarding the above-named patient to:

_____ _____ _____
(Doctor or facility receiving records) (Phone) (Fax)

For the purpose of:

- ☐ Coordinate medical, psychological, and dental services
- ☐ Develop a diagnosis and treatment plan
- ☐ Legal proceedings
- ☐ Patient request
- ☐ Transfer of care

This request and authorization applies to:

- ☐ All healthcare information and records
- ☐ All dental information, records and x-rays
- ☐ All x-rays
- ☐ All dental information and records
- ☐ Assessments (i.e. AIMS, Connors, Vanderbilt)
- ☐ Healthcare information relating to the following treatment, condition, or dates:

  Treatment or Condition: _____

  Dates: _____/_____/_____ to _____/_____/_____

- ☐ Other: _____

This release will expire in 365 days unless written revocation is given to the clinical keeper of medical records before the expiration date unless otherwise noted as follows:

Authorization for substance abuse expires on _____/_____/_____ or (condition or event) _____

Authorization for mental health, HIV, STD, or other records expires on _____/_____/_____

☐ **YES** ☐ **NO** 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.

☐ **YES** ☐ **NO** 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 fax, as described above.

_____ _____/_____/_____
(Signature of Patient or Personal Representative & Relationship) (Date Signed)

_____ _____/_____/_____
(Witness Signature) (Date Signed)

For additional information please contact Macoupin County Maple Street Keeper of Medical Records at 217-839-1526.