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

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.***