

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  
Medical/Behavioral - 217-854-3692  
FAX – 217-930-2293  
Dental - 217-854-6823

## 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)