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

Macoupin County
Public Health Department

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

HIPAA Consent to Use/Disclose Health Information

Client Name: _____ Date: _____

This form is an agreement between you and Maple Street Clinic/Morgan Street Clinic/Macoupin County Public Health Clinic Site. When we use the word "you" below, it will mean your child, relative, or other person if you are the parent/guardian of the client named above.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We use this information to decide on what treatment is best for you and to provide treatment to you, to arrange payment for your treatment or for other business or government function as permitted or required by law.

By signing this form, you are agreeing to let us use your information and/or send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent Form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we cannot treat you.

In the future we may change how we use and share your information and so we may change our Notice of Privacy Practices. If we do change it, we will post it in the waiting room, or you can get a copy from our privacy officer.

If you are concerned about some of your information, you have that right to ask us to not use or share some of your information for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations.

After you have signed this consent, you have the right to revoke it by writing a letter telling us you no longer consent and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

I have received and read the HIPAA Notice of Privacy Practices and consent to the use and disclose of my protected healthcare information as specified.

SIGNATURES

Client: _____ **Date:** _____

Parent/Guardian: _____ **Date:** _____

Witness: _____ **Date:** _____