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)

Consent for the Release of Information under 42 C.F.R. PART 2
Confidentiality of Substance Use Disorder Patient Records

Patient name: _____ Date of Birth: ___/____/_____
(Printed)

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

I, _____, authorize _____
(Name of patient) (Name of doctor or facility releasing records)

to release or disclose the substance use disorder records below:

☐ All of my substance use disorder records

Or only the following specific types of records:

☐ Appointment Attendance ☐ Upcoming Appointments ☐ Integrated Nursing Notes/MasterIMs (Office Visit Notes)
☐ Histories ☐ Patient Plans ☐ Laboratory Results ☐ Urine Drug Screening Results ☐ Diagnostic Information
☐ Insurance Information ☐ Demographic Information ☐Medication Lists ☐ Other:

_____

To:

☐ My treatment providers, health plans, third-party payers, and people helping to operate this program

If the recipient of this release or disclosure is a covered entity or business associate to whom a record (or information contained in a record) is disclosed for purposes of treatment, payment, or health care operations, your record (or information contained in the record) may be redisclosed in accordance with the permissions contained in the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you.

Or only the following specific person/organization/entity:

_____ _____
(Name of doctor or facility to which disclosure is made "Recipient") (Fax number/email address/etc.)

For (purpose of disclosure):

☐ Treatment, Payment, and Health Care Operations ☐ Civil, Criminal, Administrative, or Legislative Proceeding
☐ Transfer of Care ☐ At the Request of the Patient ☐ Other:_____

I understand I have the right to revoke my consent in writing at any time, except to the extent that the Part 2 Program or other lawful holder of my patient identifying information that is permitted to make the disclosure has already acted in reliance on it. I understand I can request a Revocation of Release of Information under 42 C.F.R. PART 2 Confidentiality of Substance Use Disorder Records from MCPHD at any time. If not previously revoked, this consent will terminate:

☐ End of Treatment
☐ One Year (365 days) from Signature Date
☐ Upon a Specific Date, Event, or Condition as Listed Here: _____

If this consent form is completed to use or disclose records for treatment, payment, or health care operations there is the potential for these records used or disclosed pursuant to the consent to be subject to redisclosure by the recipient and no longer protected by 42 C.F.R. Part 2. If you do not consent to the use or disclosure for treatment, payment, or health care operations then your substance use care at Macoupin County Public Health Department may be significantly limited.

IF THE PATIENT IS UNABLE TO SIGN DUE TO LEGAL INCAPACITY, THE SIGNATURE OF THE PATIENT'S PERSONAL REPRESENTATIVE IS REQUIRED. DOCUMENTATION OF THE PERSONAL REPRESENTATIVE'S LEGAL AUTHORITY MUST BE ATTACHED.

IF THE PATIENT IS OVER THE AGE OF 12 YEARS AND IS DEEMED TO HAVE THE LEGAL CAPACITY TO CONSENT, THE PATIENT MUST SIGN THE DOCUMENT FOR VALIDITY.

_____ _____/_____/_____

Signature of Patient if Age 12 Years or Older/Legal Guardian/Parent/Personal Representative (Date Signed)