MACOUPIN FAMILY PRACTICE CENTERS, LLP
Authorization for Release of Confidential Health Information
Carlinville, Gillespie and Mt. Olive Family Practice Centers

Patient name:_____ Telephone:_____ DOB:_____
Address:_____

I hereby authorize the protected health information regarding the above-named person to be released
FROM: ☐ **Carlinville** ☐ **Gillespie** ☐ **Mt. Olive**
Person/Institution/Other:_____
Address:_____
TO: ☐ **Carlinville** ☐ **Gillespie** ☐ **Mt. Olive**
Person/Institution/Other:_____
Address:_____

I authorize the release of information pertaining to the following time periods:
From date(s):_____ To date(s):_____

The following types of information to be disclosed are as follows:

- ☐ History and physical examination
- ☐ Consultation reports
- ☐ Progress notes
- ☐ Operative reports
- ☐ Abstract (documents summarizing history)
- ☐ Diagnostic reports (labs, x-rays, etc)
- ☐ X-ray films
- ☐ Other:_____

The following highly CONFIDENTIAL items must be checked off to be included in the disclosure:

- ☐ HIV/AIDS related health information/records (410 ILCS 305/9)
- ☐ Behavioral or mental health information/records (740 ILCS 110/1 et seq)
- ☐ Drug/alcohol diagnosis, treatment, referral information (20 ILCS 301/30.5; 42 CFR Pt. 2)
- ☐ Genetic testing information/records (410 ILCS 513/30)

The purpose(s) of this authorization is (are): _____

This release will expire 1 year after the date of signature.

- I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.
- I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until it expires, unless revoked before that.
- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclosure my health information. Written revocation must be sent to the physician's office.
- I have read and understood the terms of this Authorization and I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature, I knowingly and voluntarily authorize Macoupin Family Practice Centers, LLP to use or disclose my health information in the manner described above.

Printed name of patient, legal guardian, or authorized agent:_____
Signature of patient or legal guardian, or authorized agent:_____
Date:_____ **Relationship to patient:**_____
Staff signature:_____ **Date:**_____

*********PLEASE SEE REVERSE SIDE FOR IMPORTANT INFORMATION*********

15574 Route 108	715 West Broadway	115 North Poplar
Carlinville, IL 62626	Gillespie, IL 62033	Mt. Olive, IL 62069
(217) 854-4319	(217) 839-4491	(217) 999-4751
(217) 854-2765	(217) 839-2689	(217) 999-2317

Do you want your account with this office closed? _____no _____ yes

Dear Patient:

We would appreciate it if you would assist us in evaluating the services you have received at Macoupin Family Practice Centers, LLP and to let us know why you have asked to have your records transferred.

In order to serve your needs in the most efficient and professional manner, your response is important to us. Thank you for taking the time to share your experience.

_____I have moved to a different area and will need my records transferred to a new physician.

_____I am seeing a specialist and my records will be needed for the doctor to review.

_____My insurance plan does not cover services provided by Macoupin Family Practice Centers, LLP.

_____My insurance company has requested information to:

_____process a claim

_____complete my application for new insurance

_____I need to present medical information for:

_____school enrollment

_____job requirements

_____I am dissatisfied with:_____

_____

_____

_____