Macoupin County Public Health Department

109 E. Maple Street
Suite 5
Gillespie, IL 62033
217-839-1526 PH
217-839-1538 FAX

Maple Street Clinic

I authorize_____

To release to_____

The following (requested information is circled) lab, radiology, medications, immunizations, EKG, nurses' notes, progress notes

_____

Regarding_____Birthdate_____/_____/_____

_____
Address City State Zip

For the purpose of _____

I understand that my refusal to authorize to the release of the above mentioned information will prevent the disclosure of the information.

I understand that I have the right to inspect and copy the information that I authorize may be disclosed.

I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the privacy regulations.

I understand that the person I am authorizing to use/disclose the information will not receive compensation for doing so.

I understand that I have the right to revoke this authorization at any time by writing to
Macoupin County Public Health Department
805 N. Broad Street Carlinville, IL 62626

If not revoked, this authorization will expire 1 year from the date signed
_____/_____/_____ Date signed

_____ _____
Printed name of client Signature of personal representative

_____ _____
Signature of Client Description of Personal Representative

_____ _____
Printed Name of Personal Representative Witness