HSC
Partners In Healthcare

HUMAN SERVICE CENTER (HSC)
CONSENT to RELEASE CONFIDENTIAL INFORMATION

DUI TREATMENT VERIFICATION

I, _____ whose **birth date** is _____
(Name of Patient)

authorize HSC and their representatives to disclose to:

_____
(Name of person and/or organization to which disclosure is to be made)

_____
Address City, State, Zip Phone Fax

the following information:
Verification of treatment including treatment plan(s), diagnosis, continuing care status, discharge summaries or summaries of services and progress, and status at discharge.

for the purpose of: DOCUMENTING TREATMENT RECEIVED

This consent expires 90 days from date of authorization, unless specification of another date, event, or condition is stated here: _____

It has been explained to me that if I refuse to consent to this release of information, the following are potential consequences: Information will not be released except according to law and regulation

I understand that my records are protected under the Federal Confidentiality Regulation (42 CFR Part 2) and the Mental Health and Developmental Disabilities Confidentiality Act of Illinois and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may **(in writing)** revoke this consent at any time except to the extent that disclosure was made prior to the time I revoked it. I further understand that disclosure includes my right to inspect and receive copies of the information to be disclosed.

Executed this _____ day of _____, 20_____.

_____ _____
Signature of Client or Participant **(required age 12 or older)** Signature of Parent, Guardian or authorized representative **(required if patient is age 12-17, or if adult has legal guardian)**

_____
Signature of Witness (**required)**

Please note: there may be a charge for records

Human Service Center - Medical Records / Health Information
PO Box 1346 Peoria IL 61654-1346 Phone 309) 671-8005 Fax 309) 671-8021