HSC
Partners In Healthcare

## HUMAN SERVICE CENTER (HSC)
## CONSENT to RELEASE CONFIDENTIAL INFORMATION

# DUI TREATMENT VERIFICATION RECORDS

I, _____, whose **birth date** is_____.
**(Name of Participant)**

authorize Human Service Center and their representatives to disclose information to:

_____
(Name or Organization)

_____
**(Address)** **(City/State/Zip)** **(Telephone)**

_____
**(Email Address)**

**Regarding the following information (be specific)**: 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**

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 by 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 the right of the recipient to inspect and receive copies of the information to be disclosed.

**This consent automatically expires 90 days from date of execution unless another date, event, or condition is specified 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.

**Executed this _____ day of _____, 20_____.**

_____
**Signature of Client or Participant**

_____
**Signature of Parent, Guardian, or Authorized representative (when required)**

_____
**Signature of Witness**

Notice to Receiving Person/Organization: Under the provisions of the Mental Health and Developmental Disabilities Confidentiality Act of Illinois, you may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. A general authorization for release of medical or other information is NOT sufficient for this purpose. Under the Federal Act of August, 1987, substance abuse patient records and/or any information from such records may NOT be further disclosed without specific authorization for such re-disclosure.

Please return release to:
P.O. Box 1346 Peoria, Il 61654-1346
Questions please call 309-671-8005

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