TrilliumPlace
An affiliate of CarleHealth

Human Service Center, a subsidiary of Carle Health and Trillium Place
CONSENT TO RELEASE CONFIDENTIAL INFORMATION

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

authorize Human Service Center 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

_____
Email address

the following information (check all that apply):

- ☐ Presence and progress in treatment
- ☐ Treatment history
- ☐ Assessments & evaluations, including psychiatric evaluations
- ☐ Psychiatric notes
- ☐ History & Physical
- ☐ Nursing notes
- ☐ Nursing Assessment
- ☐ Medication information
- ☐ Results of laboratory tests
- ☐ Results of urine toxicology screens
- ☐ Treatment plans and reviews
- ☐ Discharge summaries
- ☐ Billing information
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

for the purpose of: _____

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.

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.

Executed this _____ day of _____, 20_____.

_____ _____
Signature of Client or Participant **Signature of Parent, Guardian or authorized Representative (when required)**

_____
Signature of Witness

Medical Records
600 Fayette Street PO Box 1346 Peoria, IL 61654
Tel (309) 671-8005 Fax (309) 671-8021