DuPage Medical Group-Wheaton
1800 North Main Street
Wheaton, IL 60187
630-510-6921

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

## PATIENT INFORMATION – Please complete all blanks. Incomplete forms will not be honored.

**Name:** ______________________________________ **Date of Birth:** ________________

**Address:** _____________________________________ **Telephone #:** ________________

**City/State/ZIP:** ____________________________

I hereby authorize DuPage Medical Group, and Diversified Medical Records Services on behalf of DuPage Medical Group, to use or disclose the specific records and protected health information being requested regarding the patient named above to the recipient as follows.

## RECIPIENT AND PURPOSE

Check the box for preferred method of delivery (make sure information is both **accurate** and **complete**)

☐ By US Mail: Attn: ______________________________________________________________

______________________________________________________________
(Street Address)

______________________________________________________________
(City) (State/Zip)

☐ Call for Pick Up by patient or their legal representative – All Records will be held at the site for pick up
**(Photo ID Required)**

**The purpose of the disclosure is:** ______________________________________________________

***Information to be Released – Up to 2-years of records at no charge – Add'l Records require $25 per volume <u>PREPAYMENT</u> NOTE: $25 Payable to DMRS is due at the time of request, patient will be notified of any additional charges***

## INFORMATION REQUESTED

- ❖ Please note that "All Records" will <u>NOT</u> be considered specific.

**The specific type of information to be used or disclosed is as follows:** *(Please check off all appropriate boxes)*

☐ Progress Notes ☐ Labs ☐ X-Rays ☐ Cardiac testing ☐ Specialty
☐ Medication List ☐ Immunizations ☐ Other ______________________

**For the following dates of treatment:** ____________________________________________
*(for example: specific date 1/25/03; range of dates Jan-July 2001)*

***Page 1 and 2 of this authorization must be completed.**

## *Specific Consent to use and/or disclose protected information if applicable to this authorization*

- If your record contains protected health information and you **DO** want this information released, you **MUST initial and check** in the appropriate space provided next to each choice.

_______ ☐ Information about Mental Illness or Developmental Disability

_______ ☐ Information relating to the diagnosis and/or treatment of AIDS/HIV

_______ ☐ Drug/Alcohol Abuse diagnosis, treatment, and/or referral information

_______ ☐ Information about Genetic Testing

## *Signatures*

- I understand that I have a right to revoke this authorization at any time. I understand the revocation must be in writing and must be sent to the attention of DMG's privacy officer at 1100 W. 31st Street, Suite 300, Downers Grove, IL 60515. The revocation will not apply to the extent that DMG has already taken action in reliance on the authorization.

- I understand that this authorization will terminate in 90 days or upon the following specified date or event, whichever is shorter: ______________________________ or ____________________________________ .
  *(Specified Date)* *(Specified Event)*

- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

- I understand I have the right to inspect and/or receive a copy of the medical information to be used or disclosed and also receive a copy of this authorization form.

- I understand I have the right to refuse to sign the authorization and DMG does not condition treatment on the provision of the authorization for the requested use or disclosure, except disclosure necessary to determine payment of claim (excluding authorization for use or disclosure of psychotherapy notes); or provision of healthcare solely for the purpose of creating PHI for disclosure to a third party (e.g. pre-employment or life insurance physicals).

***I HEREBY ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AS THEY APPLY TO ME. I CONSENT TO THE RELEASE OF RECORDS FOR THE PURPOSE STATED ABOVE.***

____________________________________________________________ ____________________
Signature of Patient Date

______________________________________ ____________________ ____________________
Signature of Parent/Guardian or Representative Relationship to Patient Date
(Generally required if patient is under 18 yrs old or incompetent.)

____________________________________________________________ ____________________
Signature of Witness (Mental health releases must be witnessed) Date