DuPage Medical Group

WE CARE FOR YOU

RecordConnect Copy Service, care of DuPage Medical Group
809 Ogden Avenue, Lisle, IL 60532 – 2100 Glenwood Ave, Joliet, IL 60435
Phone: 630-873-8748 Fax: 630-873-8797
Dupage.status@recordconnectinc.com

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The information that you are requesting may be available through MyChart @https://mychart.dupagemedicalgroup.com.

SECTION 1: Patient Information (please print and complete ALL blanks)

First Name:_____ Last Name: _____ Date of Birth:_____/_____/_____

Address:_____ City/State/ZIP:_____ Phone:_____

SECTION 2: Information Requested (please check all appropriate boxes)

The SPECIFIC type of information to be used or disclosed ("all records" or incomplete dates are NOT considered specific):

□ SPECIFIC Department/Physician/Clinic Location:_____
□ Radiology Reports □ Radiology Images □ Cardiac Testing □ Labs □ Medication List □ Immunizations
□ Physical Therapy □ Progress Notes □ Other:_____

Include the following **sensitive records**: □ Mental Health □ HIV/AIDS/STD □ Genetic Testing □ Drug/Alcohol Abuse
Witness signature required in Section 6 for the release of these sensitive record types; for a minor aged 12-17 the minor's signature is required in Section 6 for the release of Mental Health, HIV/AIDS/STD or Drug/Alcohol Abuse records

For the following dates of treatment:_____
(for example: specific date 1/25/2003; range of dates January-July 2001)

SECTION 3: I authorize DuPage Medical Group (DMG) to release the above patient records to:

Name of Individual/Organization:_____ Phone:_____

Address:_____ City/State/ZIP:_____ Fax:_____

SECTION 4: Method of Delivery (e-Delivery excludes radiology images)

□ Fax □ US Mail □ Secure e-Delivery (requires internet access), Email Address:_____
□Call for pick up by patient or legal representative (pick up in □ Lisle or □ Joliet – select one) ***A photo ID is required for pick up.***

SECTION 5: Purpose of Disclosure (records and CDs of radiology images are subject to charges)

□ Continuation of Care □ Personal Reasons □ Insurance □ Legal □ Other:_____

SECTION 6: Signatures

- I understand I have the right to revoke this authorization in writing at any time by sending revocation to DMG's ROI Department at 809 Ogden Ave, Lisle, IL 60543. The revocation will not apply if DMG has already taken action in reliance on the authorization.
- I understand this authorization will expire in 90 days or upon the following specified date _____ or event _____.
- I understand that information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand I have the right to inspect/receive a copy of the information used/disclosed and receive a copy of this form.
- I understand I have the right to refuse to sign this authorization and DMG does not condition treatment on this authorization, except disclosure necessary for payment of claims (excluding 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 I HAVE READ AND FULLY UNDERSTAND THE STATEMENTS AND CONSENT TO THE RELEASE OF RECORDS.

Patient Signature:_____ Date:_____

Representative Signature (for minor, etc.)_____ Relationship:_____ Date:_____

Witness Signature:_____ Date:_____
(Witness signature required for any sensitive records to be released if so selected in Section 2)