DuPage Medical Group

WE CARE FOR YOU

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)

□ Radiology Reports □ Radiology Images

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 (Reports Only) □ US Mail

□ Call for pick up by patient or legal representative ***A photo ID is required for pick up***

Select One

□ Lisle- 430 Warrenville Road □ Lombard – 1801 Highland Ave □ Tinley Park- 17495 S LaGrange Rd

□ Bloomingdale – 220 Springfield Drive □ Glen Ellyn- 430 Pennsylvania Ave

□ Rickert(Naperville) – 808 Rickert Drive

SECTION 5: Purpose of Disclosure

□ Continuation of Care □ Personal Reasons □ Insurance □ Legal
□ Transfer of care (Permanently leaving) □ 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 Radiology ROI Department at 430 Pennsylvania Ave, Glen Ellyn, IL 60137. 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)