AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
REQUEST FOR REPORTS/FILMS/CD

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

Name: **Date of Birth:**

Address: **Telephone #:**

City/State/ZIP: **GE#**

I authorize:	**Fax#**
☐ **Palos Community Hospital**	**708-923-4688**
☐ **St. James Hospital**	**708-679-2339**
☐ **Christ Advocate Hospital**	**708-684-2077**
☐ **St. Joseph Hospital**	**773-594-7439**
☐ **Silver Cross**	**815-300-7926**
☐ **Metro South**	**708-824-4431**
☐ **OTHER** _____	

RECIPIENT AND PURPOSE

Please send DICOM formatted CD/Film and/or Reports to:

DuPage Medical Group (DMG)

Radiology- Records
430 Pennsylvania Ave. Suite 110
Glen Ellyn, IL 60137
Ph: 630-545-7880

Reports may be faxed to 630-348-3640

ALL ORIGINAL FILMS WILL BE RETURNED TO YOU.

The purpose of the disclosure is: MAMMOGRAPHY COMPARISON

INFORMATION REQUESTED

- Please note that "All Records" will NOT be considered specific.

The specific type of information requested is as follows: *(Please check off all appropriate boxes)*

■Radiology Written Reports ☐Radiology Films ■ Radiology CD

For the following dates of treatment: ANY FROM PAST 5 YEARS
(for example: specific date 1/25/03; range of dates Jan-July 2001)

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

SIGNATURES

- I understand that I have a right to revoke this authorization at any time by writing to the medical record contact person at the facility records and PHI information are being requested from except to the extent that action has already been taken in reliance on this 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 this 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 (Sensitive health information releases must be witnessed) Date