DuPage Medical Group

WE CARE FOR YOU

GE#:

PLACE LABEL HERE

Patient Name:

Department:

CONSENT FOR VERBAL RELEASE OF INFORMATION

PLEASE LIST YOUR PREFERRED NUMBERS:	TYPE (please circle)	LEAVE DETAILED MESSAGE	LEAVE DETAILED LAB/TEST RESULTS
Primary Phone Number :	Home Work Cell	Yes No	Yes No
Secondary Phone Number:	Home Work Cell	Yes No	Yes No

* Answering machines and voice mail must have an identifying message to confirm these are your numbers for example; "You have reached John Doe"

1. Please list any persons with whom we MAY share details about your health care. Indicate below whether this may include sensitive health information (SHI) such as mental health, developmental disabilities, AIDS/HIV or other STD treatment and/or diagnosis, Drug/Alcohol abuse diagnosis, treatment and/or referral and Genetic Testing.

NAME	RELATIONSHIP	RELEASE SHI?
		Yes No
		Yes No
		Yes No
		Yes No

I understand that this consent is valid until it is revoked by me and applies to information about me obtained through any and all DuPage Medical Group locations and physicians. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signature: _____ Date: _____

Printed name: _____

Relationship to patient: _____