DuPage Medical Group
WE CARE FOR YOU

PLACE LABEL HERE

CONSENT FOR VERBAL RELEASE OF INFORMATION

1. Please list your preferred numbers:

   Home: ____________________ **Cell:** _______________________ **Work:** ______________________

2. Which phone number is best to use during the day (8am – 4pm)? ☐ **Home** ☐ **Cell** ☐ **Work**
3. Which phone number is best to use in the evening (4pm – 7pm)? ☐ **Home** ☐ **Cell** ☐ **Work**
4. Check box if we may leave detailed messages, including appointment reminders, on your voicemail*.

   ☐ **Home** ☐ **Cell** ☐ **Work**

5. Check box if we may leave detailed lab/test results on your voicemail*.

   ☐ **Home** ☐ **Cell** ☐ **Work.**

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

6. Please list your preferred pharmacy:

   Pharmacy Name: ____

   Pharmacy location and/or Phone: ____

7. 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: _________________________________
Patient, Parent or Guardian