

# authorization for release from

## Authorization for release of Patient Health Information of DuPage Medical Group Records

*All fields must be filled in completely for request to be processed*

I \_\_\_\_\_ Authorize DuPage Medical Group to release copies of my medical records to the following:

Person/Institution: \_\_\_\_\_

Complete Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Hold for Pick-up: \_\_\_\_\_

Purpose or need for information: \_\_\_\_\_

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Complete address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone number: \_\_\_\_\_

Specify records to be released: \_\_\_\_\_

The following fees are due in advance:

Up to a 2-year history will be provided at no charge

\$25 for complete history - charts containing more than one volume of health information may incur additional charges, patient will be notified

I understand that the information to be released may include diagnosis, evaluation and/or treatment for alcohol and/or drug abuse; Records of HIV and other STD tests and treatment; and psychiatric/psychological records or evaluation including treatment for mental, physical and/or emotional illness. If you do not wish to have the above information released, please initial here: \_\_\_\_\_

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this facility to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked, but will expire in 90 days after signing. I have a right to inspect a copy of the health information to be release and if I do not sign this Authorization, the institution named above will not release my health information, except in instances defined in the Joint Notice of Privacy Practices.

\_\_\_\_\_  
SIGNATURE OF PATIENT | DATE

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN | IF NOT PATIENT, PLEASE SPECIFY YOUR RELATIONSHIP TO PATIENT

Any patient over the age of 18 must sign their own release unless proof of Power of Attorney or Legal Guardianship is provided.

*Please note: Medical records include only services provided by DuPage Medical Group*