authorization for release to

DuPage Medical Group
WE CARE FOR YOU

Authorization for release of Patient Health Information **to DuPage Medical Group**

Release of records from previous facility

I ______________________ **Authorize** ______________________

to release copies of my medical records to the following:

DuPage Medical Group

Site: ______________________ Attn: ______________________

Complete Address: ______________________

City: ______________________ State: ______________________ Zip Code: ______________________

Purpose or need for information: ______________________

Patient name: ______________________ Date of Birth: ______________________

Complete address: ______________________

City: ______________________ State: ______________________ Zip Code: ______________________

Phone number: ______________________

Release records for the period (dates) from ______________________ to ______________________

or

Specify records to be released: ______________________

Please be aware that there may be a charge from your previous physician's office for this service

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/withdrawl 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