

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information-Please complete all blanks

Name: _____ Date of Birth: _____

Address: _____ Telephone #: _____

City/State/ZIP: _____

I authorize DuPage Medical Group (DMG) to release patient records to:

Name of Individual/Organization _____

Address _____

City: _____ State: _____ Zip: _____

Method of delivery: Check the box for preferred method of delivery

- By US Mail:
- By secure electronic delivery (requires internet access): Email Address: _____
Select a PIN Number (up to 10 digits; if not chosen date of birth will be used) _____

- Call for pick up by the patient or their legal representative. All records will be held at the site for pick up after payment is received. **A Photo ID is required to pick up records.**

Please indicate from which site you would prefer to pick up records.

- 1801 S. Highland Ave. Lombard, IL. 60148 1st floor greeter desk
 430 Pennsylvania Ave. Glen Ellyn, IL. 60137 1st floor greeter desk
 100 Spalding Drive, Suite 300, Naperville, IL. 60540 Registration desk

Name of person picking up the records, if other than the patient: _____

The purpose of the disclosure is:

- Continuation of Care Personal reasons Insurance Legal
 Other (fill-in) _____

Records of 2 years or less going to the patient or individual reports or records going to other physicians are provided at no charge. All other records require PREPAYMENT and are billed based upon the number of pages to be released.

