

3033 Ogden Avenue
Suite 101
Lisle, Illinois 60532-1976



Office: (630) 717-5700
Fax: (630) 717-0665

Authorization Form for Release of Confidential Health Information

I, _____, hereby **authorize**:
(Name of Patient or Authorized Agent)

DuPage Health Specialists
3033 Ogden Avenue, Suite 101
Lisle, IL 60532

(Name and Address of Health Care Facility, Physician, etc.)

to release to:

(Name and Address of Health Care Facility, Physician, etc.)

DuPage Health Specialists
3033 Ogden Avenue, Suite 101
Lisle, IL 60532

the following information contained in the patient record of _____
(Patient's Name)

born _____, residing at _____:
(Birthdate) (Street Address, City, State and Zip Code)

- _____ Progress/Office Notes
- _____ Operative Notes/Hospital Reports/Specialist Reports
- _____ X-ray/Radiology Reports/Cardiology Reports/EMG Reports
- _____ Laboratory/Pathology Reports
- _____ Mental Health Treatment Records
- _____ Alcoholism Treatment Records
- _____ Drug Abuse Treatment Records
- _____ HIV/Acquired Immune Deficiency Syndrome (AIDS) Records
- _____ Other: _____

The above information for the following period of time shall be released:

From: _____ to _____.
(Date) (Date)

The purpose(s) of the authorization is:

- _____ Insurance Change
- _____ Consult/Second Opinion
- _____ Out of Town Move
- _____ Selected New Physician
- _____ Legal
- _____ Insurance Claim Report
- _____ Prior Records
- _____ Other: _____

I understand that I have the right to inspect and receive a copy of the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above-described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that a prepayment for copies of my medical records is required with this form. Please contact the office at 630-717-5700 regarding applicable fees.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Without such written revocation, this Authorization for Release of Confidential Health Information will terminate on

(Date)

I am unable to pick up my records. Therefore, I authorize DuPage Health Specialists to release a copy of my medical records to _____
(Name of authorized person)

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient: _____

NOTE: Only the patient or the patient's guardian or legal representative may sign this authorization.