Authorization for Release of Confidential Health Information

DuPage Medical Group Formerly Northwest Healthcare Associates
2359 Hassell Road
Hoffman Estates, IL 60169
PH.847-843-7030 Fax.847-843-9928

Patient name:______________________________ Telephone:_______________________________
Address:__________________________________ Date of birth:____________________________
City/State/Zip:_____________________________ Medical record # (office only):________________

I hereby authorize the protected health information regarding the above-named person to be exchanged to:

Person/Institution/Other:____
Address:____
City/State/Zip:____
Phone number:____

I authorize the release of information pertaining to the following time periods:

From date(s):______________________________ To date(s):________________________________

The following types of information to be disclosed are as follows:

- ☐ History and physical examination
- ☐ Consultation reports
- ☐ Progress notes
- ☐ Operative reports
- ☐ Abstract (documents summarizing history)
- ☐ Diagnostic reports (labs, x-rays, etc)
- ☐ X-ray films
- ☐ Other:______________________________

Method of Delivery:

☐Mail ☐Fax ☐Pickup(please indicate location)____________________________________

The following highly CONFIDENTIAL items must be checked off to be included in the disclosure:

Witness signature required for the release of these sensitive record types; for a minor aged 12-17 the minor's signature is required for the release of Mental Health, HIV/AIDS/STD or Drug/Alcohol Abused records

- ☐ HIV/AIDS related health information/records (410 ILCS 305/9)
- ☐ Behavioral or mental health information/records (740 ILCS 110/1 et seq)
- ☐ Drug/alcohol diagnosis, treatment, referral information (20 ILCS 301/30.5; 42 CFR Pt. 2)
- ☐ Genetic testing information/records (410 ILCS 513/30)

The purpose(s) of this authorization is (are):____

- I understand I have the right to revoke this authorization in writing at any time by sending revocation to Midwest ROI, 3520 S. Morgan St. Suite 108, Chicago, IL 60609. The revocation will not apply if DMG has already taken action in reliance on the authorization.
- I understand this authorization will expire in 90 days or upon the following specified date ___________ or event ____________.
- I understand that information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand I have the right to inspect/receive a copy of the information used/disclosed and receive a copy of this form.
- I understand I have the right to refuse to sign this authorization and DMG does not condition treatment on this authorization, except disclosure necessary for payment of claims (excluding psychotherapy notes) or provision of healthcare solely for the purpose of creating PHI for disclosure to a third party (e.g. pre-employment or life insurance physicals).

Printed name of patient, legal guardian, or authorized agent:_______________________________

Signature of patient or legal guardian, or authorized agent:_________________________________

Date:____________________________________ **Relationship to patient:**___________________

Witness signature:______________________________ **Date:**____________________________