AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient medical information will be released upon receipt of a valid authorization.

25 N. Winfield Rd., Winfield, IL 60190-1295
TTY for the hearing impaired 630.933.4833

Patient Name ______________________ Date of Birth ______________

Address ______________________

City ______________ State ______ Zip Code ______________ Phone ______________

SELECT ONE OF THE OPTIONS BELOW:

❏ I authorize the release of the requested medical information to:

Individual or Organization's Name: ______________________

Address: ______________________

City ______________ State ______ Zip Code ______________

❏ On the patient's behalf, I authorize Central DuPage Hospital and its member organizations to directly request and receive medical information from another provider for further treatment [45 CFR 164.506(b)2 and (c)2 of the HIPAA].

Date(s) of Service: ______________________

PURPOSE:

❏ Future Treatment ❏ For Personal Records ❏ Insurance ❏ Legal ❏ Other (specify): ______________

REQUESTED MEDICAL INFORMATION:

- ❏ Billing Statement/Claim
- ❏ Cardiac Catheterization Report
- ❏ Cardiac Testing Results
- ❏ Consultations
- ❏ Dental Records
- ❏ Discharge Summary
- ❏ Drug/Alcohol Test Results
- ❏ Echo Video
- ❏ Emergency Record
- ❏ EKG/EEG Reports
- ❏ History and Physical
- ❏ HIV Test Results
- ❏ Lab Reports
- ❏ Operative Reports
- ❏ Pathology Reports
- ❏ Physician Office Record
- ❏ Physical, Occupational or Speech Therapy
- ❏ Progress Notes
- ❏ Psychiatric Assessment/ Evaluation
- ❏ Psychological Testing
- ❏ Psychosocial History
- ❏ Radiographic Images (Film, CD or Report)
- ❏ Entire Medical Record
- ❏ Other, please specify:

EFFECTIVE: This authorization will expire in ninety (90) days, unless another date is specified at signing.

NOTICE: Please note that release of your medical information to the authorized person or organization could be the subject of re-disclosure by the recipient and may not be protected by the Health Insurance Portability and Accountability Act (HIPAA) or other Federal or State laws. You may revoke ("take back") this authorization by written notice to Central DuPage Health or its member organizations. The written notice of revocation must be signed by the patient or their authorized personal representative. A copy of this authorization will be provided to you when the requested medical information is released.

Patient/Personal Representative's Signature ______________________

Relationship to Patient ______________________ Date ______________

(Signature of a witness is required for mental health, developmental disabilities, drug or alcohol abuse records.)

Witness' Signature ______________________

Relationship to Patient ______________________ Date ______________

Patient label goes here

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