CENTRAL DUPAGE HEALTH
25 North Winfield Road Winfield, IL 60190-1295 (630) 933-1600

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Specified medical information will be released for the patient as indicated below, upon appropriate completion of this authorization.

Last Name _____ First Name _____ MI ___ Maiden/Other Name _____ Date of Birth ____/____/____

Phone Number _____ Street Address _____ City and State _____ Zip Code _____

In making a request for medical information, please check one of the two options below.

☐ You are the patient, the patient's designated personal representative or the patient's guardian.

☐ You are affiliated with Central DuPage Health and its member organizations and so authorized to request medical information on behalf of the patient for further treatment. NOTE: Healthcare providers may request medical information from another provider for further treatment as codified at *45 CFR 164.506(b)2 and (c)2* of the HIPAA Privacy Rule.

Date(s) of service requested: ____/____/____ ____/____/____ ____/____/____ ____/____/____

Purpose of release: ☐ Continuation of Care ☐ Personal Reasons ☐ Insurance ☐ Legal
(REQUIRED) ☒ Other (fill-in): FOR DISCOVERY BEFORE TRIAL

Release the information from:

Name: _____
Address: _____
_____

Disclose the information to:

Name: RECORDS DEPOSITION SERVICE, INC.
Address: 120 W. MADISON STREET, STE. 300
CHICAGO, IL 60602

P: 312.553.8900 F: 312.553.8901

Requested medical information (Check those that apply):

☐ Emergency Record	☐ Pathology Report	☐ Psychological Testing	☐ Dental Records
☐ Discharge Summary	☐ Lab Reports	☐ Psychosocial History	☐ Radiology Film/CD/Report
☐ History and Physical	☐ Physical, Occupational, or	☐ Cardiac Catheterization Report	(For above, circle as necessary)
☐ Consultations	Speech Therapy	☐ Cardiac Diagnostic Testing	☐ HIV
☐ Progress Notes	☐ Psychiatric Assessments	☐ EKG/EEG Reports	☐ Drugs/Alcohol
☐ Report of Operation	☐ Psychiatric Evaluation	☐ Physician Office Record	☐ Other:_____

NOTE: While Central DuPage Health and its member organizations makes every effort to protect the privacy of your medical information, please note that release of your medical information to the authorized person or organization could be the subject of redisclosure by the recipient and therefore may no longer be protected by the Health Insurance Portability and Accountability Act ("HIPAA") or other federal or state laws. This authorization will expire within 90 days unless you specify otherwise.

Signature of Requestor _____ Relationship to Patient _____ Date ____/____/____

Witness Signature (Required when releasing records of mental health, developmental disabilities, drug or alcohol abuse.) _____

Signature of Parent/Guardian (minors age 0-17) _____ Date ____/____/____

(THE AREA BELOW IS FOR CENTRAL DUPAGE HEALTH AND ITS MEMBER ORGANIZATIONS' USE ONLY.)

Printed name of employee processing this request: _____ Date received: ____/____/____

Date Processed: ____/____/____ Medical Record Number/Account Number(s):_____

Authorization to release PHI.doc
Revision Date (05/2008) / #310eng

PATIENT LABEL GOES HERE