DuPage Medical Group

WE CARE FOR YOU

RecordConnect
801 Ogden Ave., Lisle, IL 60532
Phone: 630-873-8748
Fax: 630-873-8797
dupage.status@recordconnectinc.com

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The information that you are requesting may be available through MyChart at https://mychart.dupagemedicalgroup.com.

SECTION 1: Patient Information (please print and complete ALL fields)

First Name: ______________ Last Name: ______________ Date of Birth: ___/___/___

Address: ______________ City/State/ZIP: ______________ Phone: ______________

SECTION 2: Information Requested (please check all appropriate boxes)

Please indicate the specific type of information to be disclosed. ("All records" or incomplete dates are not considered specific.)

Charges may apply for requests for records and for images. Please contact us for details.

☐ Department/Physician/Clinic Location: ______________

☐ Radiology Reports ☐ Radiology Images (CD) ☐ Cardiac Reports ☐ Cardiac Images (CD) ☐ Labs

☐ Progress Notes ☐ Vascular Images (CD) ☐ Medication List ☐ Immunizations ☐ Billing

☑ Other: PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

Include the following specific records: ☐ Mental Health ☐ HIV/AIDS/STD ☐ Genetic Testing ☐ Drug/Alcohol Abuse

Witness signature required in Section 6 for the release of Mental Health Records.

For minors ages 12-17, the minor's signature is required in Section 6 for the release of Mental Health Records.

For the following dates of treatment: ______________

(Examples: specific date - 1/25/2013; range of dates - January-July 2014)

SECTION 3: I authorize DuPage Medical Group (DMG) to release the above patient records to:

Name of Individual/Organization: RECORDS DEPOSITION SERVICE, INC. Phone: 248-357-3330

Address: PO BOX 5054 City/State/ZIP: SOUTHFIELD/MI/48086-5054 Fax: 248-357-3337

SECTION 4: Method of Delivery (e-Delivery excludes radiology images)

☐ Fax ☐ U.S. Mail ☑ Secure e-Delivery → Email Address: INFO@RECDEP.COM

☐ Call for pickup by patient or legal representative at 801 Ogden Ave. in Lisle, IL 60532 (***photo ID is required for pickup***)

SECTION 5: Purpose of Disclosure

☐ Continuation of Care ☐ Personal Reasons ☐ Insurance ☑ Legal

☐ Transfer of Care (Permanently Leaving) ☐ Other: ______________

SECTION 6: Signature(s)

- I understand I have the right to revoke this authorization in writing at any time by sending revocation to DMG's ROI Department at 801 Ogden Ave. Lisle, IL 60532. 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 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).

I HEREBY ACKNOWLEDGE I HAVE READ AND FULLY UNDERSTAND THE STATEMENTS AND CONSENT TO THE RELEASE OF RECORDS.

Patient Signature: ______________ Date: ______________

Representative Signature (for minors, etc.): ______________ Relationship: ______________ Date: ______

Witness Signature: ______________ Date: ______________

(Witness signature required for Mental Health Records to be released if selected in Section 2)