DuPage Medical Group is now:



AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION (Void if Form is Modified)

 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 that disclosure will include Mental Health, HIV/AIDS/STD, Genetic Testing, and Drug/Alcohol Abuse information (refer to Section 3 above). 	The information that you are I SECTION 1: Patient Information			at <u>https://mychart.dupagem</u>	edicalgroup.com.
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. Please contact us for details. Cash payments are not accepted. □ Department/Physician/Clinic Location:	First Name:	Last Name:		Date of Birth:	1
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. Please contact us for details. Cash payments are not accepted. □ Department/Physician/Clinic Location:	Address:	City/State/ZIP:		Phone:	
□ Radiology Reports □ Radiology Images (CD) □ Cardiac Reports □ Cardiac Images (CD) □ Labs □ Progress Notes □ Vascular Images (CD) □ Medication List □ Immunizations □ Billing □ Other:	SECTION 2: Information Reques Please indicate the specific ty Charges	ted (please check all approp pe of information to be disc may apply. Please contact	riate boxes)* losed. ("All records" or i us for details. Cash pay	ncomplete dates are not con ments are not accepted.	
Progress Notes Vascular Images (CD) Medication List Immunizations Billing Other: **					
□ Other:	Radiology Reports	□ Radiology Images (CD)	Cardiac Reports		🗆 Labs
*For the following dates of treatment: [Examples: specific date - 1/25/2013; range of dates - January-July 2014) SECTION 3: I authorize Duly Health and Care to release the above patient records to: Name of Individual/Organization: Phone: Address: Phone: Phone: *MOTICE ABOUT SENSITIVE INFORMATION, IN ACCORDANCE WITH 45 CFR § 171.204(a)[2]: Duly's electronic medical records *Motion of the information in your medical records. THERFORE, THIS SENSITIVE INFORMATION WILL BE RELEASED To THE INDIVIDUAL/ORGANIZATION NAMED IN SECTION 3 UPON YOU SIGNING THIS FORM. ** For minors ages 12-17, the minor's signature is required in Section 6 for the release of Mental Health Records. SECTION 4: Method of Delivery (e-Delivery and MyChart excludes radiology images)	-			□ Immunizations	Billing
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Name of Individual/Organization:		· · ·			
Address:					
*NOTICE ABOUT SENSITIVE INFORMATION, IN ACCORDANCE WITH 45 CFR § 171.204(a)(2): Duly's electronic medical recors system cannot segment (1) Mental Health, (2) HIV/AIDS/STD, (3) Genetic Testing, or (4) Drug/Alcohol Abuse "sensitiv information" from other information in your medical records. THEREFORE, THIS SENSITIVE INFORMATION WILL BE RELEASED TO THE INDIVIDUAL/ORGANIZATION NAMED IN SECTION 3 UPON YOU SIGNING THIS FORM. ** For minors ages 12-17, the minor's signature is required in Section 6 for the release of Mental Health Records. SECTION 4: Method of Delivery (e-Delivery and MyChart excludes radiology images) □ Fax □ U.S. Mail □ MyChart (must have active account) □ Secure e-Delivery → Email Address: □ Pick up with photo ID (<i>will call when records are ready</i>) Individual picking up: SECTION 5: Purpose of Disclosure □ Continuation of Care □ Personal Reasons □ Insurance □ Other: □ Transfer of Care (Permanently Leaving) □ Legal * (Will include Mental Health, HIV/AIDS/STD, Genetic Testing, and Drug/Alcohol Abuse information, if included in treatment dates requested; refer to Section 2 above) SECTION 6: Signature(s) ■ I understand I have the right to revoke this authorization in writing at any time by sending revocation to Duly's ROI Department at 1100 W. 31 ^o St. Downers Grove, IL. The revocation will not apply if Duly has already acted in reliance on the authorization. ■ I understand this authorization will expire in 90 days or upon the following specified date or event ■ Lunderstand information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by law. ■ Understand I have the right to inspect/receive a copy of the information used/disclosed and receive a copy of this form. * 1 understand I have the right to revise to sign this authorization, and Duly 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 creat	Name of Individual/Organization	:		Phone:	
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 Continuation of Care Personal Reasons Insurance Other:	🗆 Fax 🗆 U.S. Mail 🗆 MyChart	(must have active account)	\Box Secure e-Delivery \rightarrow	Email Address:	
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Drug/Alcohol Abuse information, if included in treatment dates requested; refer to Section 2 above) SECTION 6: Signature(s) • I understand I have the right to revoke this authorization in writing at any time by sending revocation to Duly's ROI Department at 1100 W. 31 st St. Downers Grove, IL. The revocation will not apply if Duly has already acted 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 that disclosure will include Mental Health, HIV/AIDS/STD, Genetic Testing, and Drug/Alcohol Abuse information (refer to Section 3 above). • I understand I have the right to refuse to sign this authorization, and Duly 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:	□ Continuation of Care □ Per	sonal Reasons 🛛 🗆 Insur	rance 🗌 Other:		
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Witness Signature: Date:	Patient Signature:			Date:	
	Witness Signature:			Date:	

Representative Signature (for minors, etc.):	
DMG-ADM010	

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Relationship: _____ Date: ____