



**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM OTHER HEALTHCARE FACILITIES**

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
City/State/ZIP: \_\_\_\_\_

**I authorize:** \_\_\_\_\_

*(Name of Healthcare Facility from which Records are Requested)*

Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**to release copies of records and protected health information being requested regarding the patient named above to DuPage Medical Group.**

**SEND INFORMATION TO:**

**DuPage Medical Group (DMG)**

Department: \_\_\_\_\_ Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Fax: \_\_\_\_\_

**The purpose of the disclosure is:** \_\_\_\_\_

**INFORMATION REQUESTED**

**The specific type of information requested is as follows:** *(Please check off all appropriate boxes)*

- Diagnostic Imaging     Cardiac Testing     Labs     Medication List
- Immunizations     Physical Therapy     Progress Notes     Other \_\_\_\_\_

**For the following dates of treatment:** \_\_\_\_\_  
*(for example: specific date 1/25/03; range of dates Jan-July 2001)*

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**