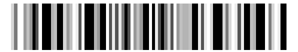
HomeCare Physicians
1800 N. Main Street
Wheaton, IL 60187
Phone: 630-614-4960
Fax: 630-682-3727



1ROI

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

Please leave this section blank

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):______________________________

Release the information from:		Disclose the information to:	
Name:	______________________	Name:	**HomeCare Physicians**
Address:	______________________	Address:	**1800 N. Main St.**
	______________________		**Wheaton, IL 60187**

Requested medical information (Check those that apply):

☐ Emergency Record	☐ Pathology Report	☐ Psychological Testing	☐ Physician Office Medical Record
☐ Discharge Summary	☐ Lab Reports	☐ Psychosocial History	
☐ History and Physical	☐ Physical Therapy, Occupational Therapy or Speech Therapy	☐ Cardiac Catheterization Report	☐ Other:______________
☐ Consultations		☐ Cardiac Diagnostic Testing	______________
☐ Progress Notes	☐ Psychiatric Assessments	☐ EKG/EEG Reports	
☐ Report of Operation	☐ Psychiatric Evaluation	☐ Radiology Reports	

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 has no expiration date.

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

______________	____/____/____
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):______________________

PATIENT LABEL GOES HERE

Authorization to release medical information finalrevised102008x
Revision Date (10/2006) / #310