AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient medical information will be released upon receipt of a valid authorization.

(You need to designate where you received treatment. Please select applicable boxes.)

CADENCE HEALTH

25 N. Winfield Rd., Winfield, IL 60190-1295
630.315.8000
TTY for the hearing impaired 630.933.4833

❏ Central DuPage Hospital
❏ Delnor Hospital
❏ HealthLab
❏ CDH Convenient Care Center (Location _____)
❏ CNS Home Health & Hospice
❏ Cadence Physician Group (Physician/Practice Name _____)

Patient Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

SELECT ONE OF THE OPTIONS BELOW:

❏ I authorize the release of medical information **from** Cadence Health and its controlled entities to:

Individual or Organization's Name _____ Phone _____

Address _____

City _____ State _____ Zip Code _____

❏ I authorize _____ to release medical information **to** Cadence Health and its
(Name of Healthcare Provider)
controlled entities, which should be sent to the attention of _____

PURPOSE:

❏ Future Treatment ❏ For Personal Records ❏ Insurance ❏ Legal ❏ Other (specify) _____

REQUESTED MEDICAL INFORMATION:

❏ Billing Statement/Claim
❏ Consulting Report
❏ Discharge Summary
❏ Films/Slides
❏ Emergency Report
❏ EKG/EEG/EMG Report
❏ History and Physical
❏ Immunization Record
❏ Lab Report
❏ Operative Report
❏ Pathology Report
❏ Progress/Physician Notes
❏ Radiographic Images (Film, CD or Report)
❏ Other, please specify: _____

DATE(S) OF SERVICE: _____

FORMAT OF MEDICAL INFORMATION T0 BE RELEASED:

❏ Paper ❏ DVD ❏ Encrypted Email (address)_____ ❏ Fax _____

EFFECTIVE: This authorization will expire in ninety (90) days unless another date is specified at signing.

NOTICE: We will not require that you complete this authorization as a condition of your treatment or payment for your health care. Medical information released to authorized individuals or organizations may be re-disclosed and no longer protected by privacy laws. Cadence Health and its controlled entities are not accountable or responsible for such re-disclosures. Lastly, you understand that you may revoke ("take-back") this authorization at any time by providing a signed written revocation to the Medical Records Department at the address above. Your revocation will only apply to disclosures that have not already occurred.

Patient/Personal Representative's Signature _____

Relationship to Patient _____ Date _____

(Signature of a witness is required for mental health, developmental disabilities, drug or alcohol abuse records. Additionally, signature of patient is required if between 12-17 years of age and the information is psychiatric, HIV/AIDS or drug/alcohol related.)

Witness' Signature _____

Relationship to Patient _____ Date _____

VERIFICATION ON RELEASE (PROVIDER USE ONLY):

Relationship to Patient _____

Employee Name (Print) _____ ID Verified _____