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.) ☐ Central DuPage Hospital ☐ CDH Convenient Care Center ☐ Cadence Physician Group 25 N. Winfield Rd., Winfield, IL 60190-1295 (Physician/Practice Name ☐ Delnor Hospital (Location \_ 630.315.8000 ☐ HealthLab ☐ CNS Home Health & Hospice TTY for the hearing impaired 630.933.4833 Patient Name Date of Birth Address Zip Code State Phone City **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 Address City Zip Code to release medical information to Cadence Health and its ☐ I authorize (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:** ☐ Radiographic Images ☐ Billing Statement/Claim ☐ Emergency Report ☐ Lab Report ☐ Chemical Dependency Records ■ Mental Health/ (Film, CD or Report) ☐ EKG/EEG/EMG Report Psychotherapy Notes Sexually Transmitted ☐ Consulting Report ☐ History and Physical Disease Records Operative Report ☐ Discharge Summary ☐ HIV/AIDS Records ☐ Other, please specify: Pathology Report ☐ Films/Slides ☐ Immunization Record ☐ Progress/Physician Notes DATE(S) OF SERVICE: \_\_\_\_ FORMAT OF MEDICAL INFORMATION TO 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

**VERIFICATION ON RELEASE (PROVIDER USE ONLY):** 

Relationship to Patient

Employee Name (Print)

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ID Verified