ipd Institute for Personal Development
a member of DuPage Medical Group

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

SECTION 1: Patient Information (please print and complete ALL fields)

First Name:_____ Last Name:_____ Date of Birth: _____

Address:_____

City/State/ZIP: _____ Phone: _____

SECTION 2: Information Requested (please check all appropriate boxes)

Please indicate the specific type of information to be disclosed. ("All records" is not considered specific.)

Charges may apply; please contact us for details.

Clinician Name/Clinic Location:_____

Record Type: ☐ Progress/Treatment Notes ☐ Lab Results ☐ Medication List ☐ Billing

☐ Other: _____

☐ Mental Health* ☐ Drug/Alcohol Abuse* ☐ STD/HIV/AIDS* ☐ Genetic Testing*

Witness signature required in Section 6. For minors ages 12-17, the minor's signature is required in Section 6.

Date(s) of Treatment:_____

(Ex. specific date: 1/25/13; range of dates: January-July 2014)

SECTION 3: I authorize IPD to release the above patient records to:

Name of Individual/Organization:_____

Address: _____

City/State/ZIP: _____ Phone: _____

SECTION 4: Method of Delivery

☐Fax: _____ ☐ E-mail: _____

☐U.S. Mail (address as indicated in Section 3) ☐ Pickup by patient or legal representative (***photo ID required***)

SECTION 5: Purpose of Disclosure

☐ Continuation of Care ☐ Personal ☐ Insurance ☐ Legal

☐ Transfer of Care (Permanently Leaving) ☐ Other: _____

SECTION 6: Signature(s)

- I have the right to revoke this authorization in writing at any time by sending revocation to the DMG Privacy Officer at 1100 W. 31st St. Downers Grove, IL 60515. The revocation will not apply if action has already been taken in reliance on this 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 I have the right to refuse to sign this authorization, and DMG/IPD 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:_____ **Date:**_____

Representative Signature:_____Relationship:_____ Date:_____

*Witness Signature:_____ Date:_____

RECORDCONNECT