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
❑ Delnor Hospital (Location _____) (Physician/Practice Name
❑ HealthLab ❑ CNS Home Health & Hospice _____)

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

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 **RECORDS DEPOSITION SERVICE, INC.** Phone **248-357-3330** fax **248-357-3337**

Address **PO BOX 5054**

City **SOUTHFIELD** State **MI** Zip Code **48086-5054**

❑ 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) PRE-TRIAL DISCOVERY

REQUESTED MEDICAL INFORMATION:

❑ Billing Statement/Claim
❑ Chemical Dependency Records
❑ Consulting Report
❑ Discharge Summary
❑ Films/Slides
❑ Emergency Report
❑ EKG/EEG/EMG Report
❑ History and Physical
❑ HIV/AIDS Records
❑ Immunization Record
❑ Lab Report
❑ Mental Health/ Psychotherapy Notes
❑ Operative Report
❑ Pathology Report
❑ Progress/Physician Notes
❑ Radiographic Images (Film, CD or Report)
❑ Sexually Transmitted Disease Records
■ Other, please specify: SEE ATTACHED SUBPOENA

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 _____ Date _____

VERIFICATION ON RELEASE (PROVIDER USE ONLY):

Relationship to Patient _____

Employee Name (Print) _____ ID Verified _____