Dupage Obstetrics & Gynecology
1N121 County Farm Rd, Winfield IL, 60190

Dr. Kevin Hussey Dr. Michael Hussey
Ph: 630.653.1500 Fax: 630.653.5066

Authorization for Release of Confidential Health Information

Patient Name:	Date of Birth: ______ / ______ / ______
Address:	Phone:
City, State:	Zip Code:

I hereby authorize that such health information regarding the above named person be forwarded:

Information from Kevin Hussey, MD or Michael Hussey, MD **RELEASED TO** (listed below):	Information **FROM** (listed below) released to Kevin Hussey, MD or Michael Hussey, MD:
Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Fax:	Fax:

I authorize the release of the following medical records:

☐ immunization report	☐ lab report	☐ radiology report
☐ operative note	☐ pathology report	☐ progress / physician note
☐ other:	☐ other:	☐ other:

I authorize the release of the following highly confidential items (*THESE MUST BE CHECKED to be included*):

☐ behavioral or mental health information / records	☐ HIV related health information / records
☐ alcohol / drug diagnosis, treatment, referral information	☐ genetic testing information / records

The purpose of this disclosure is:

☐ individual's request	☐ insurance claim	☐ research study:	☐ marketing
☐ permission to return to work, sick note, or medical excuse	☐ insurance enrollment	☐ employment purpose:	☐ other:

I authorize the release of the above medical records FROM: ______ / ______ / ______ TO: ______ / ______ / ______
Reason (specific event, end of research, etc) ____

____ I understand that I have a right to inspect and receive a copy of the information I have authorized to be disclosed by this authorization. In the event that I refuse the release of the above described information, I understand it will not be disclosed, except as provided by law. ____ I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of care is solely for the purpose of creating health information for disclosure to a third party. _____ I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law. _____ I understand that this authorization is valid until it expires, unless revoked beforehand. _____ I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. I understand this authorization will expire in 90 days or on date shown:________

Signed: ____ **Date:** ______ / ______ / ______

Please note: There may be a charge for release of records. Please call office for applicable fees.