RecordConnect Copy Service @DuPage Medical Group
809 Ogden Avenue, Lisle, IL 60532
Phone: 630-873-8748 Fax: 630-873-8797

Instructions for Completing the Authorization for Release of Information

To request a copy of your medical records, please complete the appropriate *Authorization for Release of Health Information* form and deliver in person, mail or fax to the location on the authorization form.

- To have a copy of your records from another facility sent TO DuPage Medical Group please **contact that provider directly.**
- DMG is unable to release records for Edward-Elmhurst Healthcare – please contact them directly for records from those locations.

To obtain a copy of your medical records from DMG, a valid authorization MUST contain:

Patient Information (Section 1): Provide the patient's full legal name, date of birth, address and phone number.

Information Requested (Section 2): Please be specific regarding what information is to be disclosed and the treatment or time period. Provide the specific Department/Physician/Clinic Location where services were received to expedite your request.

Requester and Recipient Information (Section 3): It is imperative that this information is accurate for the records to be received by the proper party.

- If you are requesting a copy of your own records, enter "Self" as the name of the individual.
- If you are requesting a copy of your records to be sent to another organization, enter the external individual/organization and their delivery information including fax number if applicable.

Method of Delivery (Section 4): Specify your preferred method of delivery – fax, mail, e-delivery or pick-up. If another person is picking up your records that individual MUST be individual authorized to receive records in Section 3. For your protection, a photo ID is required to pick-up records.

Purpose (Section 5): We are required by regulation to obtain information related to the purpose of the disclosure. Please check the appropriate box in this section.

Signatures (Section 6): All appropriate signatures and dates must be provided or request will not be able to be fulfilled. A representative signature (as well as verifying documents as necessary) is required to release records for certain cases where the patient is unable to sign. For certain sensitive records which are authorization to be disclosed in Section 3 a witness signature is required. The consent of a minor ages 12-17 is required in order to release information concerning care for mental health, AIDS/HIV/STDs and or drug/alcohol abuse.

Your request may be subject to fees.

There is no cost for PHI which is sent directly to another physician or medical provider. If you would like a copy of your record for yourself or to go to someone who is not a medical provider there is a cost for this service. The cost for these records is $1.00 for each page 1 to 25, $.66 for each page 26 to 50, $.33 for each page in excess of 50, $1.66 for each microfilm page. Radiology images will be provided on CD or DVD for a cost of $25.00. There will be no charge for requests for personal records for a period of 2 years prior to the date of signature on the authorization – this courtesy is for an abstract or specific individual records only; records in addition to this or prior to 2 years before the date of signature on the authorization will be charged as indicated above. All fees are in accordance with Illinois and federal law.