

**DuPage Neurosurgery, S.C.**  
2001 N. Gary Avenue, Suite 220  
Wheaton, IL 60187

**Phone: 630.858.5400**  
**Fax: 630.858.4950**

**PATIENT AUTHORIZATION FORM**

I hereby authorize you to use or disclose the specific information described below, for the purposes and parties also described below.

Description of specific information to be disclosed:

- Full medical record held by this office.
- Medical record for the period \_\_\_\_\_ through \_\_\_\_\_.
- A specific portion/section of the record as follows:

\_\_\_\_\_  
\_\_\_\_\_

**RECIPIENT:** Name and address of the person or persons to whom DuPage Neurosurgery may disclose my health information:

\_\_\_\_\_  
\_\_\_\_\_

The information is being requested for the following purpose(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TERM:** This Authorization will remain in effect from the date signed below until \_\_\_\_\_  
(Expiration date or event)

**MY HIGHLY CONFIDENTIAL INFORMATION:** I understand that these records may contain information pertaining to substance abuse, a mental illness or developmental disability, psychotherapy notes, HIV/AIDS testing or treatment, venereal disease(s), abuse of an adult with a disability, sexual assault, child abuse and neglect and/or genetic testing, and that these items may be included unless otherwise specified.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, ATTN: Privacy Officer.
- Information used and disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign or may revoke this authorization (at any time) and that you will not condition treatment or payment on my providing this authorization.

Patient Name:	
Name:	Relationship:
Signature:	Date: