

VILLAGE OF OAK BROOK
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Village of Oak Brook
Records Management Clerk
1200 Oak Brook Road
Oak Brook, IL 60523
Phone (630) 368-5056
Fax (630) 368-5042

Patient Name _____
Address _____
Phone _____ Birth date _____
Type of Report _____
Date of Incident _____

This is to authorize the Village of Oak Brook to release a copy of the above-referenced report.

TO: Person/Institution _____
Address _____
City _____ State _____ Zip Code _____

Purpose of request: Review only _____ Obtain copies _____

Other: _____

Patient Rights: As a patient, you have the right to access, copy or inspect your protected health information, or PHI, in accordance with federal law. You may also have the right to request an amendment to your PHI, or request that we restrict the use and disclosure of it. These rights are further described in our Notice of Privacy Practices and in other policies, which you may have upon request.

I understand that my records are protected and cannot be disclosed without my written consent unless otherwise provided for in the law. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically 90 days after signing.

Date _____ Signed _____
PATIENT
Signed _____
PARENT/LEGAL GUARDIAN (circle one)
Signed _____
ESTATE EXECUTOR (if patient deceased)
Signed _____
WITNESS (signature attesting to identity of above)

CERTIFICATION OF INTERPRETATION

I certify that I have read the foregoing to the signer hereof in the _____ language.

Signed _____
INTERPRETER