PMG Research of DuPage Medical Group
Medical Records Request Form

Check location:

____25 N. Winfield Road
Suite 300
Winfield, IL 60190
Office: (630) 456-7228
Fax: (630) 942-7907

____ 2155 City Gate Lane
Suite 225
Naperville, IL 60563
Office: (331) 457-6851
Fax: (630) 942-7907

____ 120 Spalding Drive
Suite 400
Naperville, IL 60540
Office: (224) 250-6431
Fax: (630) 942-7907

____ 199 Town Square
Suite A
Wheaton, IL 60189
Office: (331) 551-5667
Fax: (630) 942-7907

____ 2 Transam Plaza Drive
Suite 100
Oakbrook Terrace, IL 60181
Office: (630) 217-7935
Fax: (630) 942-7907

Authorization for Use and Disclosure of Protected Health Information for Research Purposes

Patient/Participant Name: _____
Last First Middle/Maiden
Address: _____
Street Address City State Zip Code
Date of Birth: _____

Authorization: I voluntarily authorize and direct the following Primary Care Physician ("PCP") or health care provider ("Provider") to use or disclose my health information during the term of this Authorization to PMG Research of DuPage Medical Group ("Recipient"):

_____ DuPage Medical Group *(Initial if Applicable)*

Primary Care Physician: _____
Address: _____
Phone: _____ Fax: _____

Provider's Name: _____
Address: _____
Phone: _____ Fax: _____

Hospitals or facilities where I have been treated or may be treated in the event of an emergency or surgery: (Initial if Applicable)

___ Advocate Good Samaritan Hospital
___ Northwestern Central DuPage Hospital
___ Edward Hospital
___ Elmhurst Memorial Hospital
___ Presence Saint Joseph Medical Center
___ Sherman Hospital
___ Silver Cross Hospital
___ Other hospitals or facilities: _____

To the recipient of this request: Please call our office should there be any cost associated with mailing these records to us. Please note that if we are not contacted by telephone to discuss such a fee, our office will be under no obligation to render payment. We appreciate your cooperation and compliance with this procedure.

Purpose: I understand that the specific purpose for this authorization is to allow my health information to be used in an Institutional Review Board (IRB) approved research study conducted by the Recipient, of which I am a participant.

Information to Be Disclosed:
This Authorization permits the Provider/PCP to disclose the following health information**. PLEASE INITIAL WHICH OF THE FOLLOWING CATEGORIES/TYPES OF HEALTH INFORMATION THAT YOU AUTHORIZE THE PROVIDER TO DISCLOSE:**

_____ All of my health information that the Provider/PCP has in his or her or its possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

_____ All of my health information described above except for the following:
_____

_____ Only the following records or types of health information:
_____

Re-disclosure: I understand that once the Provider/PCP discloses my health information to the Recipient identified above, the Provider cannot guarantee that the Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that my medical records/ health information will be used and shared with others by the Recipient to carry out the Research Study and as required by law. I understand that while every effort will be made by the Recipient to protect my health information, absolute privacy and confidentiality cannot be guaranteed.

If the requested portion of the record contains information pertaining to mental health or drug or alcohol treatment or contains HIV related information, you must specifically authorize the release of such information by initialing one or both of the following:

_____ I understand that if my record contains **information concerning mental health and/or drug and alcohol treatment,** I hereby authorize the release of such information.

_____ I understand that if my record contains **confidential HIV related information,** I hereby authorize the release of such information. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

Fee for Medical Records: Any fees associated with the release of my health information by the Provider pursuant to this Authorization shall be borne by the Recipient:

PMG Research of DuPage Medical Group
1100 W. 31st Street, Suite 300
Downer's Grove, IL 60515

Term of this Authorization: This Authorization has no expiration and will remain in effect for one year after the Research Study completes or until I submit in writing to revoke my Authorization.

Refusal to sign/Right to Revocation: I understand that I may refuse to sign this Authorization for any reason and that such refusal will affect my eligibility to participate in the Research Study but not affect my ability to seek medical alternatives as described in the study consent form. In addition, I may change my mind and revoke (e.g., withdraw or cancel) this Authorization at any time by writing to the Recipient at the following address: PMG Research of DuPage Medical Group c/o PMG Research, Inc., 4505 Country Club Road, Suite 110, Winston-Salem, NC 27104. I understand that even if I revoke this Authorization, my health information and medical records already obtained for the Research Study protocol may still be used and shared as necessary to maintain the integrity of the Research Study.

Questions: I may contact the Recipient for answers to my questions about the privacy of my health information. The Provider can be reached by phone at 336.608.3500 or by email at privacyofficer@pmg-research.com:

Signature:

_____ _____
Research Participant's Signature Date

If the Patient is unable to sign this Authorization, I am the Legally Authorized Representative and have the authority to sign this Authorization.

_____ _____ _____
Legally Authorized Representative's Signature Print Name Legal Relationship Date

Witness Signature (applicable only if the patient or the Legally Authorized Representative signs with the letter "X")

_____
Witness' Signature Print Name Date