NORTHWEST COMMUNITY
800 W CENTRAL ROAD
ATTN: ROI
ARLINGTON HEIGHTS, IL 60005

Request # **PZ249122**
Date: 08/10/2023

Request Date: 08/09/2023

PAUL R DULBERG

Claim/Tracking ID:

4606 HAYDEN COURT

MCHENRY, IL 60051

Dear Requestor:

Patient: DULBERG, PAUL R

This is to acknowledge receipt of your recent inquiry. The information is not available because:

The records you are requesting exceed the record retention policy of 10 years.

Please mail updated information back to the specific physician's office or facility for processing.
Sincerely,
Release of Information.

1307925

51969941

Patient Name: *(Please Print)* Paul R. Dulberg

Address: 4606 Hayden Ct.

City/State/Zip: McHenry / Illinois / 60051

Birth Date: March 19, 1970 **Phone #:** (847)497-4250

I, Paul R. Dulberg, **do hereby authorize ☒ Northwest Community Hospital/Day Surgery Center ☒**

Northwest Community Medical Group ☒ Other: _____

To release to: Agency/Facility/Person: Paul R. Dulberg

Address: 4606 Hayden Ct.

City/State/Zip: McHenry / Illinois / 60051

Phone: (847)497-4250 **Fax number:** (for physician faxing only) _____

For the purpose(s) of: ☐ Continuity of Care ☐ Attorney/client relationship ☐ Insurance ☒ Request of patient ☐ Other

Records for the period (dates) from December 1 2011 **to** Present

Release the Following Information:

☐ Discharge Summary	☐ Pathology Report(s)	☐ Emergency Record(s)	☐ History and Physical	☐ Abstract (Document Summarizing Health history and Pertinent Information)	☐ Social History
☐ Radiology Report(s)	☒ Itemized Billing Statement	☐ Consultation(s)	☐ Lab Report(s)		☐ PT/OT/Speech
☐ Operative Report(s)	☐ Cardiology Report(s)	☐ Progress Notes	☐ Treatment Plan(s)		☐ Psych Evaluation
☒ Other Records as specified: See Email request that accompanied this form					☐ Discharge Medication List
☒ Entire Medical Record (Except for Records Concerning Highly Confidential Information mentioned below).					☐ Films/CD

I also authorize the release of the following: ☐ Alcohol/Drug abuse diagnoses and treatment records
☐ Records of HIV/Aids testing, diagnoses or treatment ☐ Mental Health records ☐ Genetic Testing. (Check all that apply).

I acknowledge that I have the right to revoke this authorization. I understand that my revocation must be in writing. I also understand that my revocation will be valid except to the extent that the person(s) or organization(s) authorized to make the requested use/ disclosure have taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest the claim under the policy or the policy itself.

I understand that I have the right to inspect and copy my information that will be used or discussed pursuant to this authorization. I understand I have a right to receive a copy of this authorization.

Patient's Signature: Paul Dulberg **Date:** August 9, 2023

Signature of Minor (12-17 inclusive): _____ **Date:** _____
(mental health or emancipated minor)

Parent/Guardian/Representative Signature: _____ **Date:** _____

Relationship to Patient: _____

I attest to the identity of the above signature(s):

Witness: _____ **Date:** _____

Applicable fees will be charged for patients and attorneys. (735 ILCS 5/8-2006)

Under the provisions of HIPAA and under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, authorization for release/disclosure is voluntary. Individuals are not coerced into signing an authorization but provide the information freely. The above-named facility may not limit or restrict services, treatment or care based on the signing of this authorization. Once information is received by the authorized agency/facility or person it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. Illinois law prohibits re-disclosure of HIV, alcohol, drug abuse and genetic information by the recipient except as otherwise allowed by law. Federal regulations prohibit the recipient from making further disclosure of alcohol and drug abuse patient records except by express written consent of the patient. 42 C.F.R. Part 2. This authorization will automatically expire one year after the date of signing if no prior notice for revocation is received. All original films must be returned in 15 days. The above-named individual has requested the above records to be sent to the agency/facility/person named herein and that it not be further disclosed or used for any purpose other than as stated in this authorization. Any person who discloses mental health records and communication without proper consent/authorization may be subject to civil liability or criminal penalty according to 740 ILCS 110.

AUG 09 2023

Northwest Community Hospital
Northwest Community Day Surgery Center
Northwest Community Medical Group
Phone: 847.618.4950
Fax: 847.618.3249

13300SPS

AUTHORIZATION FOR USE or DISCLOSURE OF INFORMATION Form # 001.070-11/15-1-PS

NCH Item # 41155

From: Paul Dulberg <Paul_Dulberg@comcast.net>
Sent: Wednesday, August 9, 2023 11:37 AM
To: Record Request
Subject: [EXTERNAL] Medical Record Request - Account Number: 71265382 - Med Records Number: 0001307925
Attachments: 2023-08-09_NCH Authorization to Disclose Records form.pdf

!! ALERT
This email is from an External Sender.
DO NOT click links, open attachments, or provide sensitive information if the sender is unknown. !!

Dear Medical Records Person,

This may seem like a strange request but I am seeking my medical records and account information surrounding a surgery that I had on July 9, 2012.

Account Number: 71265382
Medical Records Number: 0001307925

Total: $6,366.00

I am requesting all records surrounding the account number and medical records number listed above, specifically but not limited to the following information:
All UB-04 forms created and produced to anyone for any reason All Statements of Accounts created and produced to anyone for any reason All Billings created and produced to anyone for any reason All Liens created and produced to anyone for any reason A copy of the Process Service of Lien Any documentation concerning the Satisfaction of the Lien - Particularly when and by whom.

I am also seeking any communications or documents communicated with anyone including but not limited to the following people or entities surrounding the lien on the Account Number and Medical Records Number listed above, the satisfaction of the lien or medical records requests and response to the requests that were made by them:
1. Auto-Owners Insurance - Claim Number: 13-2779-11 2. Thomas Malatia 3. CICERO, FRANCE, BARCH & ALEXANDER, P .C.
4. Ronald A. Barch
5. The Law Offices of Thomas J. Popovich P.C.
6. Thomas J. Popovich
7. Hans A Mast
8. Allarie Dullum
9. Allstate Insurance Company
10. Perry Accardo
11. Shoshone Reddington
12. Compex Legal Services
13. Ehrmann, Gehlbach, Badger, Lee & Considine, LLC 14. Megan G. Heeg 15. Yalden, Olsen & Willette 16. Joseph D. Olsen 17. Any other person or entity communicated with concerning the above mentioned Account Number and Medical Records Number

I understand that this information may be purged from your immediate system and in the event that it may be purged from your immediate system I do ask for you to send me the contact information for your custodian of records and that this request be forwarded to your custodian of records.

I also ask that this request be sent to your legal department and that the attorney for the legal department contact me upon receipt of this request.

I have filled out the Authorization to Disclose Records form and attached it to this email as a pdf.

I understand that these records cost money to produce and am willing to pay in advance for any fees associated with the production of the records.

Thank you in advance for your help with this matter.

Sincerely,
Paul

Paul Dulberg
847-497-4250
4606 Hayden Ct.
McHenry, Illinois 60051