Northwestern Memorial Physicians Group

Corporate Health Services
Chicago (phone) 312-926-8282
(fax) 312-926-3093
Lake Forest (phone) 847-535-6172
(fax) 312-926-3093

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Name: _____ **Birth Date:** _____

Phone Number: _____ **Social Security Number:** _____

Address: _____ **City, State, Zip:** _____

RECORDS TO BE RELEASED FROM:

☐ **Northwestern Memorial Physicians Group**
Corporate Health Services, Chicago
676 N. Saint Clair St., Suite 900
Chicago, IL 60611
Fax: 312-926-3093

☐ **Northwestern Memorial Physicians Group**
Corporate Health Services, Lake Forest
660 N. Westmoreland Rd.
Lake Forest, IL 60045
Fax: 312-926-3093

RECORDS TO BE RELEASED TO:

I hereby authorize Northwestern Memorial Physicians Group to release information to:

Agency/Facility/Person Name: _____

Phone Number: _____ **Fax Number:** _____

Address: _____ **City, State, Zip:** _____

I request that records be sent via: ☐ **Fax** ☐ **US Mail**

Records cannot be emailed. Please contact our office to make other arrangements. Turnaround time for requests is 7-10 days.

INFORMATION TO BE RELEASED

☐ **Employee Health Summary** ☐ **Discharge Summary** ☐ **Clinical Notes** ☐ **Work Capacity Reports**
☐ **Radiology Reports** ☐ **Diagnostic Imaging Films** ☐ **Immunization History**
☐ **Other:** _____

Concerning the care of the above patient between these dates: _____ and _____

The information being released may contain sensitive health information regarding topics such as mental health, substance abuse, or HIV/AIDS. Such information will be released unless checked below:

☐ **Mental Health** ☐ **Substance Abuse** ☐ **HIV/AIDS** ☐ **Other:** _____

This information is being requested for the purpose of:

☐ **Continuity of Care** ☐ **Attorney/Client Relationship** ☐ **Insurance** ☐ **At the request of the patient**

PATIENT CONSENT

I understand that I have the right to inspect the disclosed information and may revoke this authorization at any time in writing except to the extent that records have already been released. In the event that written revocation of this consent is not made, this authorization will automatically expire in (6) months unless expiration date is otherwise amended. I understand that all radiology films will be returned to the hospital unless purchased as my own property.

_____ _____ _____

Signature: Patient or Legal Representative **Relation to Patient** **Date**

The Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, state that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient. The Federal Confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug and alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information does NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR41997. Nov. 2, 1987]