

AUTHORIZATION FOR RELEASE OF INFORMATION

Mail or fax this Authorization to:

Northwestern Memorial Physicians Group
Deerfield
350 S Waukegan Road
Deerfield, Illinois 60015
Fax: 312-926-2185

Print Patient's Name _____
 Address _____ City/State/Zip _____
 Date of Birth ___/___/___ Last 4 digits of SSN _____ Phone () _____
 I _____ hereby authorize Northwestern Memorial Physicians Group to release
 (written/oral/electronic) information to:
 Agency/Facility/Person _____
 Address: _____ City/State/Zip _____

INFORMATION TO BE RELEASED FROM:

<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Corporate Health and Travel	<input type="checkbox"/> Dermatology	<input type="checkbox"/> Follow-up Clinic
<input type="checkbox"/> Northwestern Integrative Medicine	<input type="checkbox"/> OB/Gynecology	<input type="checkbox"/> Pediatrics	<input type="checkbox"/>

Please specify the name of your Provider(s): _____

- Record Abstract (History and Physical, Progress Notes, Lab, Radiology, Operative Report, Pathology Report, Consultation Report and other diagnostic tests)
- Patient review of record
- Other (Please specify) _____

Concerning the care of the above patient from dates _____ to _____

This abstract *WILL* include sensitive information such as mental, substance abuse, or HIV/AIDS unless checked below. (Check all that apply)

- Mental Health
- Substance Abuse
- HIV/AIDS
- Other _____

These records are released for the purpose of (Check all that apply)

- Continuity of Care
- Attorney/client relationship
- Insurance
- At the request of the patient

Allow 5 – 10 Business Days To Honor Requests for Paper Record / Radiology Images on CD

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 Legally Authorized Patient Representative

Date of Signature

Relationship to Patient

Signature of Witness

Date of Signature

*Please refer to website www.nmpg.com for patient copy fees.

For Internal Use Only: Date Copied: _____ By Whom: _____

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 re-disclosure 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 specifically permitted by the written consent of the patient or unless otherwise permitted by 42 CFR part 2.