



AUTHORIZATION FOR RELEASE OF INFORMATION

Records to be released from:

Northwestern Memorial Physicians Group
Deerfield ICC Office
350 S Waukegan Rd
Deerfield, Illinois 60015
Fax: 312-694-2340

Please mail authorization form to the address listed above

If records to be released are prior to 1974, please indicate hospital:

- Passavant Memorial Hospital
- Wesley Memorial Hospital

Print Patient's Name _____

Address _____ City/State/Zip _____

Date of Birth ___/___/___ Social Security Number ___ - ___ - ___ Phone () _____

I _____ hereby authorize Northwestern Memorial HealthCare

to release (written/oral/electronic) information to:

Agency/Facility/Person _____

Address: _____ City/State/Zip _____

INFORMATION TO BE RELEASED

- Discharge Summary Operative Reports Pathology Reports Radiology Reports
- Radiology Films/Images Lab Reports Clinic/Office Record Psychological testing/assessment
- Treatment Planning Form Consultations Integrated Assessment Slides
- 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 _____

MNorthwestern Memorial
Hospital

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 For Processing

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

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 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 FR 41997, Nov. 2, 1987]