Northwestern Memorial Physicians Group

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: (Please print neatly) ____________________________________ Date of Birth: ________________
Address: ____ Phone number:___________________

Release records ☐ TO / ☐ FROM:

Northwestern Memorial Physicians Group
Robert J. Hartman, M.D.
660 Westmoreland Rd., Suite 302
Lake Forest, IL 60045
Phone# (847)615-2229 Fax# (847-615.2260

Release records ☐ TO / ☐ FROM:

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____
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____
____

(Please fax or mail all forms to above)

Information to be released: (check all that apply)
☐ Record Abstract (history and physical, progress notes, labs, radiology, operative report, pathology report, consultation report and other diagnostic tests)
☐ Patient review of record
☐ Discharge summary ☐ Operative Reports ☐ Pathology Reports ☐ Radiology Reports
☐ Lab Reports ☐ Clinic/Office Record ☐ Consultations
☐ Other (please specify)____
____

Concerning the care of the above patient from dates _________ to __________

This abstract *WILL* include sensitive information such as mental health, substance abuse, or HIV/AIDS unless checked below. *(Please check all that apply.)*
☐ Mental Health ☐ Substance Abuse ☐ HIV/ AIDS ☐ Other ______________

These records are released for the purpose of *(Please check all that apply.)*
☐ Continuity of Care ☐ Attorney/ client relationship ☐ Insurance ☐ At the request of the patient

Please allow 7-14 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 six (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: _________
Relationship to Patient: ____
Signature of Witness: ____ Date: _________

For Internal Use Only:
Date copied: ________
By Whom: __________

The Standards of 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 CFF 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]