



**M**Northwestern 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.

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Signature: Patient or Legally Authorized Patient Representative

Date of Signature

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Relationship to Patient

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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 FR41997, Nov. 2, 1987]*