Northwestern Memorial Physicians Group

AUTHORIZATION FOR RELEASE OF INFORMATION

Mail or fax this Authorization to:

Northwestern Memorial Physicians Group
Libertyville
1800 Hollister Drive, Suite 102
Libertyville, Illinois 60048
Fax: 847-680-3994

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:

❑ Internal Medicine	❑ CorporateHealth and Travel	❑ Dermatology	❑ Follow-up Clinic
❑ Northwestern Integrative Medicine	❑ OB/Gynecology	❑ Pediatrics	❑

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/AIDSunless 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 expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.