Northwestern Memorial Hospital

AUTHORIZATION FOR RELEASE OF INFORMATION

Records to be released from:

Northwestern Memorial Physicians Group
OB/Gyne Office
680 N Lake Shore Drive, Suite 810
Chicago, IL 60611
Fax: 312-926-8855

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** _____

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.

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 FR41997. Nov. 2, 1987]

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