

**AUTHORIZATION FOR RELEASE OF INFORMATION**

**Patient Name: (Please print neatly)** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

Release records  TO /  FROM:

Release records  TO /  FROM:

**Northwestern Memorial Physicians Group**

**111 West Washington Street**

**Chicago, IL 60602**

**Phone # 312.726.8800**

**Fax # 312.726.9460**

(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]