

AUTHORIZATION FOR RELEASE OF INFORMATION

Records to be released from:

- | | | |
|---|--|---|
| <input type="checkbox"/> Northwestern Memorial Hospital
251 East Huron Street
M-702
Chicago, Illinois 60611-2908
Phone: 312-926-3248
Fax: 312-926-3093 | <input type="checkbox"/> Northwestern Memorial
Physicians Group (NMPG)
680 N Lake Shore Dr
Suite 818
Chicago, Illinois 60611-2908
Phone: 312-926-3627 | <input type="checkbox"/> HOLD FOR PICK-UP |
|---|--|---|

Please mail authorization form to the appropriate 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 ____/____/____ Last 4 digits of SSN _____ 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

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> Radiology Images* <i>*Please contact Radiology 312.926.5100 Or Mail to: Above address + Radiology Rm 4-712</i>	<input type="checkbox"/> Slides*** <i>***Please contact Pathology Department 312.926.3211</i>	<input type="checkbox"/> Clinic/Office Record** <i>**Please contact your Physician's Office directly</i>	<input type="checkbox"/> Psychological testing/assessment
<input type="checkbox"/> Treatment Planning Form	<input type="checkbox"/> Consultations	<input type="checkbox"/> Integrated Assessment	<input type="checkbox"/> Lab Reports

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 _____

(Please see other side)

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 To Honor Requests for Paper Record / Radiology Images on CD

Patient Copy Fees:

- \$0.89 per page for 1 – 25 page(s)
- \$0.59 per page for each additional page over 25 pages through 50 pages
- \$0.30 per page for each additional page over 50 pages through 9,999 pages
- \$1.49 per page for microfilmed pages

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 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.