Northwestern Medicine®

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Instructions: Please print clearly and complete both pages.

PATIENT INFORMATION

First Name | Last Name | Maiden/Other Name(s) | Date of Birth MM/DD/YYYY

( ) -

Address | Phone Number

City | State | ZIP Code

RELEASE INFORMATION FROM

I authorize Northwestern Memorial HealthCare and its clinical affiliates to release information from *(check all that apply)*:

Hospital:

- ☐ Catherine Gratz Griffin Lake Forest Hospital
- ☐ Central DuPage Hospital
- ☐ Delnor Hospital
- ☐ Huntley Hospital
- ☐ Kishwaukee Hospital
- ☐ Marianjoy Rehabilitation Hospital
- ☐ McHenry Hospital
- ☐ Northwestern Memorial Hospital
- ☐ Palos Hospital
- ☐ Valley West Hospital
- ☐ Woodstock Hospital

Physician Group:

☐ Northwestern Medical Group/Northwestern Medicine Regional Medical Group ☐ Florida Medical Group

Other:

☐ Behavioral Health Location(s): _____

☐ Other Location(s): _____

☐ All Northwestern Memorial HealthCare Entities

PURPOSE OF INFORMATION RELEASE

☐ Further Treatment/Continued Care ☐ Personal Use ☐ Attorney/Client ☐ Insurance

Other *(specify)* _____

MEDICAL RECORDS TO BE RELEASED

Requested delivery date _____

MEDICAL RECORDS REQUESTED – For Dates of Service: From _____ To _____

(If no dates listed, records will include the past 24 months.)

Please check all that apply:

☐ **Emergency Department Visit** (ED provider notes, progress notes, consultations, procedure notes, test results)

☐ **Hospital Stay** (History and physical, progress notes, consultations, operative reports, discharge summary, test results)

☐ **Outpatient Surgery/Procedure** (History and physical, progress notes, consultations, procedure notes, test results)

☐ **Clinic, Office Visit or Immediate Care** (Office notes, progress notes, procedure notes, test results)

Specify Clinic, Office or Physician _____

☐ **Test Results/Reports Only** *(check all that apply):* ☐ Laboratory ☐ Radiology ☐ Other *(specify)* _____

☐ **Other Records** – Please specify _____

Method of Delivery *(select one)*: ◯ MyNM ◯ Fax ◯ E-mail to _____

◯ US Mail (select format: ☐ CD ☐ Paper)

Other Instructions _____

To request medical images, see page 2.

MEDICAL IMAGES TO BE RELEASED

Requested delivery date _____

MEDICAL IMAGES REQUESTED – For Dates of Service: From _____ To _____
(If no dates listed, records will include the past 24 months)

Please check all that apply:

☐ Radiology Images (specify CT, MRI, X-ray, Ultrasound, Nuclear Medicine) _____

☐ Mammography Images ☐ Cardiology Images ☐ Other *(specify)*_____

☐ Include Reports With the Images

Images will be sent on a CD, by US mail, or through electronic exchange, if available.

SEND INFORMATION TO

_____
Name (Example: Healthcare Facility, Insurance Company, Attorney)

Street Address	City	State	ZIP Code
( ) -	( ) -		
Phone Number	Fax Number		

Unless checked below, I understand that the released information may include the following information. Check if you do NOT want to include:

☐ AIDS or HIV testing information or test results	☐ Genetic testing and/or genetic counseling records
☐ Information about treatment for substance/alcohol abuse	☐ Mental health and developmental disability records

I understand that Northwestern Memorial HealthCare has up to 30 days to review and respond to requests. Once the organization or person authorized to receive this information ("the recipient") has received it, the recipient may release it to others. If this is the case, the information may no longer be protected by federal privacy laws; however, Illinois law does not allow the re-release of AIDS/HIV, genetic testing, mental health and developmental disabilities information by recipients except in precise situations allowed by law. If applicable, I understand that if the recipient is subject to HIPAA, they may use and re-disclose my substance use disorder information as allowed by HIPAA, except for uses or disclosures for civil, criminal, administrative or legal proceedings against me. Also, Federal Confidentiality Rules, 42 CFR part 2 prohibits unauthorized use or disclosure of these records.

I understand that if I do not sign this authorization form, Northwestern Memorial HealthCare clinical affiliates may not deny me care based on the fact that I did not sign it. However, those clinical affiliates may refuse to provide care to me if the care is being provided only for the purpose of collecting health information to be released to a third party (for example, pre-employment exams).

I know that I have the right to withdraw (take back) this authorization at any time. I must do this in writing. Any withdrawal will be valid except for the release of information that occurred before I withdrew this authorization. (For information on how to withdraw this authorization, contact the Northwestern Memorial HealthCare Health Information Management Department at 877.973.2673 [TTY: 711].)

I understand that I have the right to inspect and copy the mental health and developmental disabilities records that will be released.

I understand that if I do not withdraw this authorization, it is valid for a period of 6 months from the date of signature. It allows release of records past the date signed as long as the authorization is still in effect. Standard record copying fees per 735 ILCS 5/8-2006 may apply.

By signing below, I agree to the statements in this authorization form.

- **Patients 12 to 17 years of age** must sign for mental health and developmental disability, substance/alcohol abuse treatment, AIDS or HIV testing or test results, sexually transmitted infections, pregnancy, sexual assault, or birth control information.

Time	Date	Patient Name/Signature for Patients Age 12 or Over
Time	Date	Signature of *(circle one):* Parent Guardian Legal Representative

Submit request to one of the following:

(1) Mail: Northwestern Medicine
HIM – Release of Information Department
25 North Winfield Road
Winfield, Illinois 60190

(2) Fax: 312.926.3093

(3) E-mail: releaseofinformation@nm.org

Questions? 877.9RECORD • (877.973.2673) • TTY: 711