

AUTHORIZATION FOR RELEASE OF INFORMATION

Records to be released from:

HOLD FOR PICK-UP _____
CREATE PDF _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Northwestern Memorial Hospital
251 East Huron Street
Medical Records-Customer Service
Galter/2 nd Floor / 2-158
Chicago, Illinois 60611-2908
Phone: 312-926-3248
Fax: 312-926-3093 | <input type="checkbox"/> Northwestern Memorial Physicians Group (NMPG)
www.nmpg.com
Phone: 312-926-3627 | <input type="checkbox"/> Northwestern Lake Forest Hospital
Health Information Management /
Medical Record Department
660 North Westmoreland Road
Lake Forest, IL 60045
Phone: 847-535-8205
Fax: 847-535-7825 |
|---|--|---|

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 Imaging- Release of Info</i> NMH- Fax Number 312.926.7886 NLFH – Fax Number 847.535.7836	<input type="checkbox"/> Slides*** <i>***Please contact Pathology Department</i> NMH - 312.926.3211 NLFH – 847.535.6218	<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 _____

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

Standard Record copying fees
Per 735 ILCS 5/8-2006

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: _____

revised 09/2013

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.