Northwestern Memorial® HealthCare

Authorization for Release of Information

Records to be released from:

HOLD FOR PICK-UP ❒

❒ 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

❒ Northwestern Memorial Hospital
251 East Huron Street
Medical Records-Customer Service
Galter/2nd Floor / 2-158
Chicago, Illinois 60611-2908
Phone: 312.926.3248
Fax: 312.926.3093

❒ Northwestern Memorial
Physicians Group (NMPG)
nmpg.com
Phone: 312.926.3627

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

❒ Discharge Summary	❒ Operative Reports	❒ Pathology Reports	❒ Radiology Reports
❒ Radiology Images* *Please contact Imaging- Release of Info NMH – Fax Number 312.926.7886 NLFH – Fax Number 847.535.7836	❒ Slides*** ***Please contact Pathology Department NMH – 312.926.3211 NLFH – 847.535.6218	❒ Clinic/Office Record** **Please contact your Physician's Office directly	❒ Psychological testing/ assessment
❒ Treatment Planning Form	❒ Consultations	❒ Integrated Assessment	❒ Lab Reports

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❒ 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

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.