Northwestern Memorial Hospital

AUTHORIZATION FOR RELEASE OF INFORMATION

Records to be released from:

- ☐ **Northwestern Memorial Hospital**
  251 East Huron Street
  Medical Records-Customer Service
  Feinberg/2nd Floor / 2-304H
  Chicago, Illinois 60611-2908
  Phone: 312-926-3248
  Fax: 312-926-3093
- ☐ **Northwestern Memorial Physicians Group (NMPG)**
  680 N Lake Shore Dr
  Suite 818
  Chicago, Illinois 60611-2908
  Phone: 312-926-3627
- ☐ **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

☐ **Discharge Summary**	☐ **Operative Reports**	☐ **Pathology Reports**	☐ **Radiology Reports**
☐ **Radiology Images*** ***Please contact Imaging- Release of Info 312.926.5100 Fax # 312.926.7886 Or Mail to: Above address + Image Release / Feinberg / Lower Concourse - L330***	☐ **Slides***** *****Please contact Pathology Department 312.926.3211***	☐ **Clinic/Office Record**** ****Please contact your Physician's Office directly***	☐ **Psychological testing/assessment**
☐ **Treatment Planning Form**	☐ **Consultations**	☐ **Integrated Assessment**	☐ **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)**

____

Northwestern Memorial Hospital

(Please see other side)

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

Patient Copy Fees:

- ❑ **$.93 per page for 1 – 25 page(s)**
- ❑ **$.62 per page for each additional page over 25 pages through 50 pages**
- ❑ **$.31 per page for each additional page over 50 pages through 9,999 pages**
- ❑ **$1.55 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:

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.