Northwestern Medicine®

Today's date ___________________

Needed by ____________________

PATIENT LABEL

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO NORTHWESTERN MEMORIAL HEALTHCARE

1. PATIENT INFORMATION

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

Address | Phone Number ( ) -

City | State | ZIP Code

2. RELEASE INFORMATION FROM

Name (Example: Health Care Facility, Physician's Office, Insurance Co.) | Phone Number | Fax Number

Street Address | City | State | ZIP Code

FOR THE PURPOSE OF: ☐ Further Treatment/Continued Care ☐ Other *(specify)*____________________

DATES OF SERVICE TO BE RELEASED

Dates of Service to Release: FROM ____________________ TO ____________________

RECORDS TO BE RELEASED *(indicate all that apply)*

☐ Clinic/Office Visits ☐ Consultations ☐ Discharge Summary ☐ History & Physical

☐ Emergency Department Reports ☐ Operative/Procedure Reports ☐ Abstract of Record ☐ Complete Record

☐ Test Results/Reports (for example, Cardiac, Laboratory, Pathology, Radiology) – *Specify:*

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Other (for example, images, pathology slides) – *Specify*: ____________________

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3. RECIPIENT OF INFORMATION AT NORTHWESTERN MEMORIAL HEALTHCARE

Name of Recipient (Specify Office, Clinic, Facility, Dept.) | Phone Number | Fax Number

Street Address | City | State | ZIP Code

Select one: ☐ Fax ☐ Mail ☐ Secure electronic delivery (if secure delivery, provide email)____________________

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PATIENT LABEL

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO NORTHWESTERN MEMORIAL HEALTHCARE

I, the undersigned, authorize the above named sending facility/provider as described in section 2 to release health information as indicated/described above.

Unless checked or listed below, I understand the released information may include any or all of the following. Check and/or list if you do NOT want to include:

☐ AIDS or HIV testing information or test results

☐ Substance abuse/alcohol treatment

☐ Genetic testing and/or genetic counseling records

☐ Mental health and developmental disability records

☐ Other *(specify)* ______________________________

I UNDERSTAND THAT:

Treatment, payment, enrollment or eligibility for benefits will not be based on whether or not I sign this authorization.

I have the right to withdraw this authorization at any time. My withdrawal must be in writing. Any withdrawal will be valid except for the release of information that occurred prior to this authorization being withdrawn. If not withdrawn, this authorization is valid for a period of six (6) months from the date of signature and allows release of records past the date signed as long as the authorization is still in effect. For information on how to withdraw this authorization, contact the facility/provider as described in section 2. Any revocation will not apply to information that has already been released in response to this authorization.

Once Northwestern Memorial HealthCare's clinical affiliate or person authorized to receive this information has received it, the information may be able to be re-released by the clinical affiliate or person. If this is the case, the information may no longer be protected by federal privacy laws; however, Illinois law does not allow re-release of AIDS/HIV, genetic testing, mental health and developmental disabilities information by the receivers of the information except in precise situations allowed by law. Also, Federal Confidentiality Rules, 42 CFR Part 2, prohibits unauthorized disclosure of these records.

I understand that the sender of my health information may charge for the service of disclosing medical information and I am responsible for inquiring about these potential charges. I understand I have the right to inspect and copy the mental health and developmental disabilities records that will be released.

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

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

Time ____________ Date ______________ Patient Signature ______________________________

Time ____________ Date ______________ Signature ______________________________

(Circle one): Parent Guardian Legal Representative

Time ____________ Date ______________ Witness Signature ______________________________