

## **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

PATIENT INFORMATION							
First Name Last	Name	Maiden/Other Nam	e(s) Date	of Birth			
Address			Phone Number				
City		State	ZIP Code				
	RELEASE INFO	RMATION FROM					
I authorize Northwestern Memoria (check all that apply):	l HealthCare ("NMHC")	and its clinical affilia	ites to release infor	mation from			
Hospital:  Central DuPage Hospital Delnor Hospital Huntley Hospital Kishwaukee Hospital	<ul><li>□ Lake Forest Hospita</li><li>□ Marianjoy Rehabilit</li><li>□ McHenry Hospital</li><li>□ Northwestern Mem</li></ul>	ation Hospital	☐ Palos Hospital ☐ Valley West Ho ☐ Woodstock Hos	•			
Physician Group:							
$\square$ Northwestern Medical Group (NMG)	☐ Regional Medical	Group (RMG)					
Other:							
☐ Behavioral Health: Location(s)							
☐ Other							
☐ All NMHC Entities							
	PURPOSE OF INFO	RMATION RELEASE					
☐ Further Treatment/Continued Care  Other (specify)	☐ Personal Use	☐ Attorney/Client	□ Insurance				
( )		S TO BE RELEASED					
Requested delivery date							
-		n	To				
MEDICAL RECORDS REQUESTED-For Instructions: Please check all that app  ☐ Emergency Room Visit (ER notes) ☐ Hospital Stay (History and physica) ☐ Outpatient Surgery/Procedure (H) ☐ Clinic, Office Visit or Immediate ☐ Specify Clinic, Office or Physician	oly. , progress notes, consult al, progress notes, consu History and physical, pro Care (Office notes, progr	ations, procedure note: Itations, operative repo gress notes, consultation ress notes, procedure n	s, test results) rts, discharge summa ons, procedure notes, otes, test results)	ry, test results) test results)			
☐ Test Results/Reports Only (check							
☐ <b>Other Records</b> - Please specify	, , , ,	5	( , , , , , , , , , , , , , , , , , , ,				
Method of Delivery (select one): □ NI							
- '	S Mail (select format: $\Box$						
Other instructions							

To request medical images, see page 2.

MEDICAL IMAGES TO BE RELEASED							
Request	ed delivery date	<del> </del>					
MEDICAL	IMAGES REQUESTED-FO	r Dates of Service	: From	To			
Instructio	ons: Please check all that o	ipply.					
☐ Mamm	ography images 🔲 Card	iology images 🗆	Other (specify)				
☐ Include	e reports with the images						
lmages w	vill be sent on a CD by US r	nail.					
		SENI	D INFORMATION TO				
Please s	end my information to:						
Name (Ex	cample: Health Care Facilit	y, Insurance Co., At	torney)				
Street Ad	dress		City	State	ZIP Code		
Phone Nu	ımber		Fax Number				
Unless checked below, I understand 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 ar	nd/or genetic counseling	records		
☐ Subst	ance abuse/Alcohol treatr	nent	☐ Mental health and	l developmental disability	/ records		
informatio no longer l health and	nd that NMHC has up to 30 d n has received it, the informa be protected by federal priva I developmental disabilities in Infidentiality Rules, 42 CFR p	ation may be re-releas cy laws; however, Illir nformation by the rec	sed by that organization on nois law does not allow th eivers of the information	or person. If this is the case, e re-release of AIDS/HIV, ge except in precise situations	the information may enetic testing, mental		
form; how	nd that if I do not sign this at ever, NMHC clinical affiliates ormation to be released to a t	may refuse to provide	care to me if the care is	being provided solely for the			
release of	right to withdraw this autho information that occurred pri 1HC Health Information Mana	or to this authorization	on being withdrawn. For i				
I understand that I have the right to inspect and copy the mental health and developmental disabilities records that will be released.							
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. Standard record copying fees per 735 ILCS 5/8-2006 may apply.							
<ul><li>Patient HIV test</li><li>Witness</li></ul>	g below, I agree to the starts are starts as 12-17 years of age must ting or test results, sexually solved for notice tient/self.	sign for mental healt transmitted infections	h and developmental disa s, pregnancy, sexual assau	ult, or birth control informati	on.		
Time	Date	Patient Name/	'Signature for patients ag	e 12 or over			
Time	Date	Signature of (d	theck one): 🗆 Parent	☐ Guardian ☐ Legal Re	presentative		
Time	Date	Witness/Signa	iture				
	equest to one of the follow Northwestern Medicine HIM - Release of Information 25 North Winfield Road Winfield, Illinois 60190		• •	.3093 eofinformation@nm.org <i>9RECORD • (877.973.2673</i>	3)		