

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

First Name	Last Name	Maiden/Other Name(s)	Date of Birth
Address		Phone Number	
City	State	ZIP Code	

RELEASE INFORMATION FROM

I authorize Northwestern Memorial HealthCare ("NMHC") and its clinical affiliates to release information from (check all that apply):

Hospital:

- | | | |
|--|--|---|
| <input type="checkbox"/> Central DuPage Hospital | <input type="checkbox"/> Lake Forest Hospital | <input type="checkbox"/> Palos Hospital |
| <input type="checkbox"/> Delnor Hospital | <input type="checkbox"/> Marianjoy Rehabilitation Hospital | <input type="checkbox"/> Valley West Hospital |
| <input type="checkbox"/> Huntley Hospital | <input type="checkbox"/> McHenry Hospital | <input type="checkbox"/> Woodstock Hospital |
| <input type="checkbox"/> Kishwaukee Hospital | <input type="checkbox"/> Northwestern Memorial Hospital | |

Physician Group:

- Northwestern Medical Group (NMG) Regional Medical Group (RMG)

Other:

- Behavioral Health: Location(s) _____
- Other _____
- All NMHC Entities

PURPOSE OF INFORMATION RELEASE

- Further Treatment/Continued Care Personal Use Attorney/Client Insurance

Other (specify) _____

MEDICAL RECORDS TO BE RELEASED

Requested delivery date _____

MEDICAL RECORDS REQUESTED-For Dates of Service: From _____ To _____
(If no dates listed, records will include the past 24 months)

Instructions: Please check all that apply.

- Emergency Room Visit** (ER notes, progress notes, consultations, procedure notes, test results)
- Hospital Stay** (History and physical, progress notes, consultations, operative reports, discharge summary, test results)
- Outpatient Surgery/Procedure** (History and physical, progress notes, consultations, procedure notes, test results)
- Clinic, Office Visit or Immediate Care** (Office notes, progress notes, procedure notes, test results)

Specify Clinic, Office or Physician _____

- Test Results/Reports Only** (check all that apply): Laboratory Radiology Other (specify) _____

Other Records - Please specify _____

Method of Delivery (select one): NM MyChart Fax E-mail to _____
 US Mail (select format: CD Paper)

Other instructions _____

To request medical images, see page 2.

