Northwestern Medicine®

PATIENT LABEL

# AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION

## PATIENT INFORMATION:

LAST NAME, FIRST NAME M.I. DATE OF BIRTH LAST 4 DIGITS OF SS #

STREET ADDRESS CITY STATE ZIP CODE PHONE

I hereby authorize the facility listed below to disclose my health information as circled to the Northwestern Medicine affiliate listed below:

## INFORMATION RELEASED FROM:

/

NAME (Example: Health Care Facility, Physician's Office, Insurance Co.) PHONE NUMBER/FAX #

STREET ADDRESS CITY STATE ZIP CODE

Clinical/Office Records Complete Chart Consultations Discharge Summary Laboratory/Pathology/Slides
Operative Reports Radiology Film/Images Radiology Reports Record Abstract

Other (please specify) **Mammography, Breast Ultrasound, Breast MRI, Pathology Reports, Breast Biopsy**

DATES OF SERVICE FROM **5 Years Prior** TO **Present**

SPECIAL INSTRUCTIONS (such as specific information, lab only, etc.) _____

## INFORMATION RELEASED TO (please check appropriate location below):

☐ **CDH Breast Health Center**
25 North Winfield Road
Winfield, Illinois 60190
Fax: 630.933.2872

☐ **Delnor Center for Breast Health**
351 Delnor Drive
Suite 201
Geneva, Illinois 60134
Attn: Center for Breast Health
Fax: 630.208.3856

☐ **Kishwaukee Hospital**
5 Kish Hospital Drive
Suite 102
DeKalb, Illinois 60115
Attn: Breast Health Center
Fax: 815.766.9672

☐ **Lake Forest Hospital**
1000 North Westmoreland Road
Lake Forest, Illinois 60045
Attn: Breast Care Center
Fax: 847.535.7863

☐ **Lynn Sage Comprehensive Breast Center**
250 East Superior Street
Fourth Floor, Suite 420
Chicago, Illinois 60611
Fax: 312.926.7403

☐ **McHenry Hospital**
4201 Medical Center Drive
McHenry, Illinois 60050
Attn: Medical Imaging File Room
Fax: 815.759.4319

☐ **Palos Hospital**
12251 South 80th Avenue
Palos Heights, Illinois 60463
Attn: Medical Imaging File Room
Fax: 708.923.8845

☐ **Valley West Hospital**
1302 North Main Street
Sandwich, Illinois 60548
Attn: Breast Health Center
Fax: 815.981.7375

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## PURPOSE OR NEED FOR DISCLOSURE – CHECK ALL THAT APPLY:

☑ Continuity of Care

☐ Request of the patient identified above

☐ Other (specify)_____

**I UNDERSTAND THAT:**

If I do not sign this authorization, Northwestern Memorial HealthCare's clinical affiliates may not deny me care based on my unwillingness to sign this form. However, Northwestern Memorial HealthCare clinical affiliates may refuse me care that is being provided solely for the purpose of collecting health information to be released to a third party (e.g., pre-employment exams). 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. For information on how to withdraw this authorization, contact the NMH Health Information Management Department at 312.926.3375. 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, 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.

I understand 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 months from the date of signature. Standard record copying fees per 735 ILCS 5/8-2006 may apply.

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

Time _____ Date _____ Patient Signature _____