Northwestern Medicine®

AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

LAST	FIRST	M.I.	BIRTH DATE

STREET ADDRESS

CITY	STATE	ZIP CODE

INFORMATION RELEASED FROM:

NAME OF HEALTH CARE ENTITY

STREET ADDRESS

CITY	STATE	ZIP CODE	PHONE NUMBER

I hereby authorize the above listed health care entity to disclose my health information as provided below to Northwestern Medicine Lynn Sage Comprehensive Breast Center, 250 E. Superior St, 4th Floor, Chicago Illinois, 60611. Phone 312-472-0469 Fax 312-926-7403.

Please provide any and all of the below from within the last 5 years *or* the patient's last 5 Mammograms:

1) Mammogram Films and Reports
2) Original film/analog Mammograms and/or CD of Digital Mammograms, Breast Ultrasounds and Breast MRI'S
3) Pathology Results from biopsy procedures

INABILITY TO WITHHOLD TREATMENT ON EXECUTION OF THIS AUTHORIZATION

I understand that my health care provider may not withhold treatment on my executing this authorization except that my health care provider may withhold health care that is solely for the purpose of creating health information for disclosure to a third party.

RIGHT TO REVOKE

I understand that I have the right to revoke this authorization. I understand that my revocation must be in writing. I also understand that my revocation will be valid except to the extent that my health care provider has taken action in reliance to this authorization.

REDISCLOSURE

Once the organization or person authorized to receive this information has received it, the information may be re-released by that organization or person. If this is the case, the information may no longer be protected by federal privacy laws.

EXPIRATION

If not revoked, this authorization is valid for one (1) year from the date of signature.

SIGNATURE

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

SIGNATURE: _____ **DATE:** _____

If being executed by a representative on behalf of patient, please indicate relationship to patient:

RELATIONSHIP: _____