Northwestern Medicine®

TREATING LOCATION: _____
FAX: _____
PHONE: _____

AUTHORIZATION TO OBTAIN CONFIDENTIAL INFORMATION

PATIENT INFORMATION:

_____

LAST NAME, FIRST NAME | M.I. | BIRTHDATE | LAST 4 DIGITS OF SS #

_____

STREET ADDRESS | CITY | STATE | ZIP CODE

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

_____

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) _____

DATES OF SERVICE FROM _____ TO _____

SPECIAL INSTRUCTIONS (e.g. specific information, lab only, etc.) _____

INFORMATION RELEASED TO:

_____

NAME (Example: Physician's Office, Clinic/Office, Department) | PHONE NUMBER

_____

STREET ADDRESS | CITY | STATE | ZIP CODE

_____

TO THE FOLLOWING NORTHWESTERN MEMORIAL HEALTHCARE CLINICAL AFFILIATES:

- ☐ Northwestern Memorial Hospital
- ☐ NM Marianjoy Rehabilitation Hospital
- ☐ NM Lake Forest Hospital
- ☐ NM Lake Forest Hospital – Grayslake
- ☐ NM Central DuPage Hospital
- ☐ NM Delnor Hospital
- ☐ NM Valley West Hospital
- ☐ NM Proton Center
- ☐ Northwestern Medical Group
- ☐ KishHealth System Physician Group
- ☐ Marianjoy Medical Group
- ☐ NM Kishwaukee Hospital
- ☐ NM KishHealth Ben Gordon Center
- ☐ NM KishHealth Cancer Center
- ☐ NM Cancer Center - Warrenville
- ☐ NM Cancer Center - Geneva
- ☐ Regional Medical Group
- ☐ Other _____

Northwestern Medicine®

TREATING LOCATION: _____
FAX: _____
PHONE: _____

PURPOSE OR NEED FOR DISCLOSURE – CHECK ALL THAT APPLY:

☐ Continuity of Care

☐ Request of the patient identified above

☐ Other (specify)_____

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:

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.

Signature:_____ Date: _____

Witness:_____ Relationship to Patient: _____