

CORPORATE HEALTH SERVICES AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT/EMPLOYEE INFORMATION

Name: _____ Birth Date: _____
Phone Number: _____ Social Security Number: _____
Address: _____ City, State, Zip: _____

RECORDS TO BE RELEASED FROM:

- Corporate Health- Northwestern Memorial Hospital Corporate Health- Lake Forest Hospital Corporate Health- Marianjoy Rehab Hospital
 Corporate Health-Central Dupage Hospital Corporate Health-Delnor Hospital Corporate Health-Kishwaukee Hospital

RECORDS TO BE RELEASED TO:

I hereby authorize Northwestern Memorial HealthCare to release information to:

Agency/Facility/Person Name: _____
Phone Number: _____ Fax Number: _____
Address: _____ City, State, Zip: _____

I request that records be sent via: Fax US Mail

Records cannot be emailed. Please contact our office to make other arrangements. Turnaround time for requests is 7-10 days.

INFORMATION TO BE RELEASED

- Employee Health Summary Discharge Summary Clinical Notes Work Capacity Reports
 Radiology Reports Diagnostic Imaging Films Immunization History
 Other: _____

Concerning the care of the above patient between these _____ and _____ dates: _____

The information being released may contain sensitive health information regarding topics such as mental health, substance abuse, or HIV/AIDS. Such information will be released unless checked below:

- Mental Health Substance Abuse HIV/AIDS Other: _____

This information is being requested for the purpose of:

- Continuity of Care Attorney/Client Relationship Insurance At the request of the patient

PATIENT CONSENT

I understand that I have the right to inspect the disclosed information and may revoke this authorization at any time in writing except to the extent that records have already been released. In the event that written revocation of this consent is not made, this authorization will automatically expire in (6) months unless expiration date is otherwise amended. I understand that all radiology films will be returned to the hospital unless purchased as my own property.

Signature: Patient or Legal Representative Relation to Patient Date

The Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, state that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient. The 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. A general authorization for the release of medical or other information does NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR41997. Nov. 2, 1987]

Please email or fax this form to the following: CorpHealth@nm.org or Fax to 312-926-9071