Northwestern Medicine®

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:

- ☐ Central DuPage Hospital
- ☐ Delnor Hospital
- ☐ Huntley Hospital
- ☐ Kishwaukee Hospital
- ☐ Lake Forest Hospital
- ☐ Marianjoy Rehabilitation Hospital
- ☐ McHenry Hospital
- ☐ Northwestern Memorial Hospital
- ☐ Palos Hospital
- ☐ Valley West Hospital
- ☐ Woodstock 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.

MEDICAL IMAGES TO BE RELEASED

Requested delivery date _____

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

Instructions: Please check all that apply.

☐ Radiology images (specify CT, MRI, X-ray, Ultrasound, Nuclear Med) _____

☐ Mammography images ☐ Cardiology images ☐ Other *(specify)* _____

☐ Include reports with the images

Images will be sent on a CD by US mail.

SEND INFORMATION TO

Please send my information to:

Name (Example: Health Care Facility, Insurance Co., Attorney)

Street Address City State ZIP Code

( ) - ( ) -

Phone Number Fax Number

Unless checked below, I understand the released information may include the following information. Check if you do NOT want to include:

☐ AIDS or HIV testing information or test results	☐ Genetic testing and/or genetic counseling records
☐ Substance abuse/Alcohol treatment	☐ Mental health and developmental disability records

I understand that NMHC has up to 30 days to review and respond to requests. 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; however, Illinois law does not allow the 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 prohibits unauthorized disclosure of these records.

I understand that if I do not sign this authorization, NMHC clinical affiliates may not deny me care based on my unwillingness to sign this form; however, NMHC clinical affiliates may refuse to provide care to me if the care is being provided solely for the purpose of collecting health information to be released to a third party (for example, 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 NMHC Health Information Management Department at 877.973.2673.

I understand that 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 (6) months from the date of signature and allows release of records past the date signed as long as the authorization is still in effect. Standard record copying fees per 735 ILCS 5/8-2006 may apply.

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

- **Patients 12-17 years of age** must sign for mental health and developmental disability, substance abuse/alcohol treatment, AIDS or HIV testing or test results, sexually transmitted infections, pregnancy, sexual assault, or birth control information.
- **Witness/Signature** is required for mental health and developmental disability information, and genetic counseling to recipient other than patient/self.

Time Date Patient Name/Signature for patients age 12 or over

Time Date Signature of *(circle one):* Parent Guardian Legal Representative

Time Date Witness/Signature

Submit request to one of the following:

(1) Mail: Northwestern Medicine
HIM - Release of Information Department
25 North Winfield Road
Winfield, Illinois 60190

(2) Fax: 312.926.3093

(3) E-mail: releaseofinformation@nm.org

Questions? 877.9RECORD • (877.973.2673)