Northwestern Medicine®

Health Information Management
Centers of Excellence
541 N Fairbanks Ct Suite 1500
Chicago, IL 60611
Fax: 312-926-4184 Phone: 312-926-4788

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 the Northwestern Memorial HealthCare 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 Lab/Pathology/Slides
Operative Reports Radiology Film/Images Radiology Reports Record Abstract

Other: _____

DATES OF SERVICE FROM _____ TO _____

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

INFORMATION RELEASED FROM:

_____

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

_____

STREET ADDRESS CITY STATE ZIP CODE

TO THE FOLLOWING NORTHWESTERN MEMORIAL HEALTHCARE CLINICAL AFILIATES:

- ☐ Northwestern Memorial Hospital
- ☐ Northwestern Medical Group (Formerly Northwestern Faculty Foundation and successor to Northwestern Memorial Physicians Group)

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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 that 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 treatments
- ☐ 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 many 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 the federal privacy laws. However, Illinois law does not allow re-release of AIDS/HIV, genetic testing, mental health and development 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 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: _____