NORTHWESTERN MEDICAL CENTER, INC.

AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT HEALTH INFORMATION

_____ _____

Patient Name **Date of Birth**

Medical Record #: _____ **Account #:**_____

1. I hereby authorize _____ to:
   _____ obtain my information from
   _____ release my information to:

   _____
   Name
   _____
   Street Address
   _____
   City, State, Zip Code

2. Information to be released: Treatment Dates:_____

___ History & Physical Examination	___ Physician Orders
___ Discharge Summary	___ Laboratory Reports
___ Diagnostic Imaging Report	___ EKG/Cardiology Reports
___ Emergency Department Report	___ Operative Reports
___ Pathology Reports	___ Progress Notes
___ Rehab Reports (PT/OT/SLP)	___ Digital Images
	Digital Images created by_____

Other (specify): _____

3. **There are no limitations** placed on dates, history of illness or diagnostic/therapeutic information, including any treatment of alcohol, drug, HIV/AIDS, mental health, behavioral health or psychiatric and/or psychotherapy notes or treatment.

THE SIGNER MUST INITIAL THIS CLAUSE: _____ OR QUALIFY #3 ABOVE

4. The above information is released for the following purpose and that purpose only:

___ Continuation of Care	___ Legal Purposes
___ Insurance Purposes	___ Employer Requirement
___ Personal Reason	
___ Worker's Compensation	___ Other:_____

Revocation Process: I understand that I must place my request in writing to the Privacy Officer; I can revoke this authorization at any time. However, I understand that a health care organization cannot take back information that has already been released in response to this Authorization. I understand that the revocation of this Authorization will not apply to my insurance company whenever my insurer has a legal right to contest a claim under my policy.

Continued on reverse →

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This authorization **will expire one (1) year from the date of my signature** or as otherwise specified by date, event or condition as follows:

_____.

5. **Right to Copy/Voluntary Disclosure:** I know that I have the right to receive a copy of this Authorization after I sign it and that authorizing the disclosure of my health information is voluntary.

6. **Health Plan/Insurance Issuers-Conditions:** I need not sign this form in order to receive treatment, to have my treatment paid for by my insurer, for enrollment in a health plan, eligibility for its benefits or if I am authorizing my information to be released to an insurance company. I have been advised by my insurer of my rights and the consequence to me should I refuse to sign this Authorization.

7. **Photocopy:** I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that Northwestern Medical Center may deny the release of protected health information if it has reason to believe:
   (1) this authorization has been altered or
   (2) is not a true and accurate authorization initiated by the patient.

REDISCLOSURE: I understand that authorizing the disclosure of this protected health information is voluntary. I understand that any disclosure of information carries with it the potential of unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

SIGNER MUST INITIAL THIS CLAUSE: _____

_____ _____

Patient's Signature **Date**
(*Photo identification or verification of signature is required*)

_____ _____

Signature of Legal Representative/Relationship to Patient **Date**
(Photo identification may be required)

Department Use Only:

Requires Supporting Document to Prove Authority to Act on behalf of Patient – Please Attach.

☐ Photo ID from patient/legal representative verified

Information released per authorization by _____ on date: _____.

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