Northwestern Medicine
Attn: Medical Records
25 North Winfield Road
Winfield, Illinois 60190

877.9RECORD Phone
(877.973.2673)
312.926.3093 Fax
releaseofinformation@nm.org

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient medical information will be released upon receipt of valid authorization.
Please tell us where you received your treatment by placing an (X) next to the location.

- ☐ 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

Patient Name | Date of Birth (/ /)

Address | Phone number ( ) -

City | State | Zip Code

I authorize Northwestern Memorial HealthCare ("NMHC") and its clinical affiliates to release information to the following party at the below address:

RECORDS DEPOSITION SERVICE, INC.	248-357-3330	248-357-3337
Name (Example: Health Care Facility, Insurance Co., Attorney, Self)	Phone Number	Fax Number

PO BOX 5054	SOUTHFIELD	MI	48086-5054
Street Address	City	State	Zip Code

Purpose:

☐ Future Treatment ☐ Personal Use ☐ Insurance ☐ Attorney/Client ☑ Other (specify) PRE TRIAL DISCOVERY

Requested Medical Information:

- ☐ Inpatient Record Abstract
- ☐ Outpatient Record Abstract
- ☐ ED Report
- ☐ History and Physical
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Progress/Physician Notes
- ☐ Diagnostic Images
- ☐ Diagnostic Imaging Report
- ☐ Laboratory Report
- ☐ Immunization Record
- ☐ Films/Slides

Records for the period (dates) from _____ to _____.

Unless specifically requested otherwise, NMHC will only release the last ten (10) years of your medical records.

Additional Information (Example: physician name, specific test/result)

PLEASE NOTE YOUR RECORD PREFERENCES:

☐ **Mail records** (please provide mailing address in the designated area on the first page of this form) ☐ **Fax records** (please provide fax number in the designated area on the first page of this form) ☐ **Hold for pick up at:** ☐ Northwestern Memorial Hospital ☐ NM Central DuPage Hospital ☐ NM Delnor Hospital ☐ NM Lake Forest Hospital ☐ NM Marian Joy Rehabilitation Hospital ☐ NM Valley West Hospital ☐ NM Kishwaukee Hospital	**Requested format:** ☐ Paper ☐ Electronic (CD)

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

☐ AIDS or HIV testing information or test results	☐ Sexually Transmitted Infections (if minor)
☐ Substance abuse/Alcohol treatment	☐ Sexual Assault/Abuse (if minor)
☐ Genetic testing and/or genetic counseling records	☐ Child Abuse/Neglect (if minor)
☐ Mental health and developmental disability records	☐ Pregnancy (if minor)
☐ Other (specify) _____	☐ Birth Control (if minor)

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, 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.

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 312.926.3376.

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. Standard record copying fees per 735 ILCS 5/8-2006 may apply. **By signing below I agree to the statements in this authorization form.**

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

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

Time Date Witness/Signature