Northwestern Medicine®

541 N Fairbanks, Suite 1475
Chicago, IL 60611
312-926-3376 Phone
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AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION:

LAST NAME, FIRST NAME	M.I.	BIRTHDATE	LAST 4 DIGITS OF SS #

STREET ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	WORK PHONE NUMBER

I authorize Northwestern Memorial HealthCare and its clinical affiliates Northwestern Memorial Hospital, Northwestern Lake Forest Hospital, Northwestern Medical Group (collectively "NMHC") to release information to the following party at the following address:

RECORDS DEPOSITION SERVICE, INC.			248-357-3330
NAME (Example: Health Care Facility, Insurance Co., Attorney, Self)			PHONE NUMBER
PO BOX 5054	SOUTHFIELD	MI	48086-5054
STREET ADDRESS	CITY	STATE	ZIP CODE

PLEASE NOTE YOUR RECORD PREFERENCES:

☐ Hold records for pickup at 251 E Huron, 2-158, Chicago, IL 60611	☐ Provide Record in electronic format (cd) ☐ Mail records

INFORMATION TO BE RELEASED: To better serve you, please describe the information to be released as set forth on page 2 of this form.

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

☐ AIDS or HIV testing information or test results ☐ Substance abuse/Alcohol treatment ☐ Genetic testing and/or genetic counseling records	☐ Mental health and developmental disability records ☑ Other (specify) PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

REASON FOR DISCLOSURE (RELEASE OF INFORMATION) – CHECK ALL THAT APPLY:

☐ Continuity of care/other provider ☐ Request of the patient identified above ☐ Attorney/client relationship	☐ Request of the patient identified above ☐ Insurance ☑ Other (specify) PRE TRIAL DISCOVERY

I UNDERSTAND THAT

If I do not sign this authorization, Northwestern Memorial HealthCare's clinical affiliates may not deny me care based on my unwillingness to sign this form. However, Northwestern Memorial HealthCare 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 (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 Any withdrawal will be valid except for the release of information that occurred prior to this authorization being withdrawn.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 312-926-3376.

Once the organization or person authorized to receive this information has received it, the information may be able to 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 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 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 record copying fees per 735 ILCS 5/8- 2006 may apply.

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

Patient Name:_____
Date of Birth: _____

Signature:_____ Date: _____

Witness:_____ Relationship to Patient: _____

Please provide the following information about the records being requested so that we can better assist you. For date of service, please list a specific date or a range of dates. For location of service, please use the following key:

NMH = Northwestern Memorial Hospital NMG = Northwestern Medical Group	NLFH = Northwestern Lake Forest Hospital

Type of Record	Location of Service		Date of Service
Outpatient (e.g., Office Visit Notes)	• NMH • NMG	• NLFH • Other_____	• Date/Date range:_____
Inpatient (e.g., Hospitalization Notes, Discharge Summary, Operative Report)	• NMH • NMG	• NLFH • Other_____	• Date/Date range:_____
Record Abstract	• NMH • NMG	• NLFH • Other_____	• Date/Date range:_____
Other Records (specify)	• NMH • NMG	• NLFH • Other_____	• Date/Date range:_____

IMPORTANT: PLEASE READ. For some types of records, you will need to contact the service locations listed below to obtain records.

TYPE RECORD	SERVICE LOCATION	
Diagnostic Imaging	Northwestern Memorial Hospital	312-926-5518/312-926-7886 (fax)
	Northwestern Lake Forest Hospital	847-535-6315/847-535-7836 (fax)
	Northwestern Medical Group	Please contact the Department where the service was performed.
Billing Records	Northwestern Memorial Hospital	312-926-6900
	Northwestern Lake Forest Hospital	847-535-6100
	Northwestern Medical Group	312-695-9696
Mammography	Northwestern Memorial Hospital	312-472-0431/312-926-7403 (fax)
	Northwestern Lake Forest Hospital	847-535-6469/847-535-7863 (fax
Pathology	Northwestern Memorial Hospital	312-926-3211
	Northwestern Lake Forest Hospital	847-535-6218
	Northwestern Medical Group	312-695-0007 (fax)