NorthShore
University HealthSystem

Medical Group

Pediatric Endocrinology

Phone (847) 663-8508
Fax (847) 663-8506

Consent for Verbal Release of Information/Personal Representative

Patient Name and Date of Birth:_____

Consent for Verbal Release of Information (for 13 years and above)

1. Patient's preferred phone number in order of priority

   Primary:_____ Home Cell Work

   Secondary:_____ Home Cell Work

2. Can we leave detailed messages on phone number above, including lab results/test results on your voicemail*?

   YES NO

***Answering machines and voice mail must have an identifying message to confirm these are your numbers. For example "you have reached John Doe"**

3. Please list other individuals with whom we can share details about your health care. For each individual listed, also indicate whether we can share Sensitive Heath Information (SHI) including mental health, developmental disabilities, AIDS/HIV or other STD treatment or diagnosis, Drug/Alcohol abuse diagnosis, treatment and/or referral and Genetic Testing.

Name (Last, First)	Relationship to Patient	Phone Number	Release SHI? (Yes or No)

I understand that consent is valid until revoked by me and applies to information about me or my children obtained through and all NorthShore Medical Group locations and physicians. I understand that revocation muse be presented in writing to this physician's office. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose health information.

Parent/ Guardian Signature:_____Date:_____

Relationship of person Signing (circle one) Parent Guardian