



AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION
0000-106 (9/08)

Patient Name _____ Date of birth _____

Address _____

M.R. # or SS # _____ Phone _____

I AUTHORIZE NORTHSORE UNIVERSITY HEALTHSYSTEM TO RELEASE TO:

Name _____
(If an individual, describe the relationship to the patient)

Address _____

THE FOLLOWING INFORMATION FROM THE ABOVE NAMED PATIENT'S RECORD

Please check off appropriate box(es)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Clinic records | <input type="checkbox"/> Neuropsychological Report | <input type="checkbox"/> HIV antibody reports | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Neuropsychological raw testing data | <input type="checkbox"/> Alcohol/chemical | <input type="checkbox"/> School/educational history |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Face sheet with diagnosis | <input type="checkbox"/> Operative/pathology reports | <input type="checkbox"/> Medical Genetics, see attachment |
| <input type="checkbox"/> Emergency room reports | <input type="checkbox"/> History and physical | <input type="checkbox"/> X-ray films only | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Psychotherapy notes | <input type="checkbox"/> Lab reports | <input type="checkbox"/> X-ray reports | |

Approximate dates of treatment _____

Purpose/need for information (specify the use of the information to be disclosed): _____

THE FOLLOWING STATEMENT APPLIES ONLY TO RECORDS RELATING TO PSYCHIATRIC TREATMENT

I understand that my refusal to authorize disclosure of the above-mentioned information will prevent disclosure of the information.

The consequences of refusal to authorize may include incomplete diagnostic evaluation, recommendations or treatment.

Additional consequences of refusal to authorize may be: _____

Signature of patient or authorized legal guardian _____ date _____

Relationship to patient, if signed by authorized representative _____

Signature of witness (if applicable) _____ date _____

Authorization to fax records - Per NorthShore University HealthSystem policy is limited to use of fax record by healthcare provider for patient care purposes.

NOTICE TO PATIENT

I understand that this consent is valid for 90 days from the date of signature, or until calendar date ____/____/____. I understand that as set forth in NorthShore University HealthSystem notice of Health Information practices, that I may revoke this authorization at any time by giving written notice to the Medical Record Department of the NorthShore University HealthSystem except to the extent that NorthShore University HealthSystem has already acted in reliance on this contract. This authorization will automatically expire when the information requested has been disclosed, if I have given no prior notice as stated above. I understand I have the right to review and obtain the information to be disclosed. I understand that information disclosure pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. For psychiatric, psychological and social work records, Release of Information regulations as stated in the Illinois Mental Health Confidentiality Act will take precedence.

CHARGES: THERE IS A CHARGE FOR COPYING MEDICAL RECORDS