0000-106

NorthShore University HealthSystem

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

0000-106 (9/08)

Patient Name _____ Date of birth_____

Address _____

M.R. # or SS #_____ Phone_____

I AUTHORIZE NORTHSHORE 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)

- ☐ Clinic records
- ☐ Consultations
- ☐ Discharge summary
- ☐ Emergency room reports
- ☐ Psychotherapy notes
- ☐ Neuropsycho/psychological Report
- ☐ Neuropsycho/psychological raw testing data
- ☐ Face sheet with diagnosis
- ☐ History and physical
- ☐ Lab reports
- ☐ HIV antibody reports
- ☐ Alcohol/chemical
- ☐ Operative/pathology reports
- ☐ X-ray films only
- ☐ X-ray reports
- ☐ Psychiatric
- ☐ School/educational history
- ☐ Medical Genetics, see attachment
- ☐ Other _____

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 consquences 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

MUST USE BLACK BALLPOINT PEN