

Patient Name: (Please Print) \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Phone #: \_\_\_\_\_

I, \_\_\_\_\_, do hereby authorize Northwest Community Hospital/Day Surgery Center and Northwest Community Medical Group/to release to:

Agency/Facility/Person: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

The following information:

Check One: \_\_\_\_\_ Complete Chart (All Records) \_\_\_\_\_ Abstract (Document Summarizing Health History & Pertinent Information) \_\_\_\_\_ Outpatient Services (Lab, X-ray, Cardiology) If other, please specify \_\_\_\_\_ Medical Group (Office Visits)

\_\_\_\_\_ OTHER: \_\_\_\_\_ (Specific Reports or Films)

Concerning the hospitalization/visit of (date(s) of discharge/service): \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_

For the purpose(s) of \_\_\_\_\_

I acknowledge that I have the right to revoke this authorization. I understand that my revocation must be in writing and must be witnessed by a person that can attest to my identity. I also understand that my revocation will be valid except to the extent that i) the person(s) or organization(s) authorized to make the requested use/disclosure have taken action in reliance on this authorization or ii) if this authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest the claim under the policy or the policy itself.

I understand that the person(s) or organizations authorized to make the requested use and/or disclosure may not condition treatment, payment, enrollment or eligibility for benefits, on execution of this authorization. I understand that this authorization includes the release of information related to HIV if applicable.

By signing below, I acknowledge and affirm the statements in this authorization form.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Guardian/Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I attest to the identity of the above signature(s):

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Applicable fees will be charged for patients and attorneys.**

Notice to receiving person/agency. Under the provisions of HIPAA, authorization for use and/or disclosure is voluntary. Individuals are not coerced into signing an authorization, but provide the information freely. Once information is received by the authorized organization or person, then it may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws. Illinois Law prohibits re-disclosure of HIV, alcohol, drug abuse, and genetic information by the recipient except as otherwise allowed by law. This authorization will automatically expire 90 days after the date of signing if no prior notice for revocation is received. All original films must be returned within 15 days.

**Northwest Community Hospital  
Northwest Community Day Surgery Center  
Northwest Community Medical Group**

Phone: 847.618.4977  
Fax: 847.618.4986



**AUTHORIZATION FOR USE and/or DISCLOSURE  
OF INFORMATION**