Patient Name: *(Please Print)* _____

Address: _____

City/State/Zip: _____

Birth Date: _____ **Phone #:** _____

I, _____, **do hereby authorize ☐ Northwest Community Hospital/Day Surgery Center ☐ Northwest Community Medical Group ☐ Other:** _____

To release to: Agency/Facility/Person: _____

Address: _____

City/State/Zip: _____

Phone: _____ **Fax number:** (for physician faxing only) _____

For the purpose(s) of _____

Records for the period (dates) from _____ **to** _____

Release the Following Information:

☐ Discharge Summary ☐ Pathology Report(s) ☐ Emergency Record(s) ☐ History and Physical ☐ Abstract (Document Summarizing Health history and Pertinent Information) ☐ Social History
☐ Radiology Report(s) ☐ Itemized Billing Statement ☐ Consultation(s) ☐ Lab Report(s) ☐ PT/OT/Speech
☐ Operative Report(s) ☐ Cardiology Report(s) ☐ Progress Notes ☐ Treatment Plan(s) ☐ Psych Evaluation
☐ Other Records as specified: _____ ☐ Discharge Medication List
☐ Entire Medical Record (Except for Records Concerning Highly Confidential Information mentioned below). ☐ Films/CD

I also authorize the release of the following: ☐ ***Alcohol/Drug abuse diagnoses and treatment records***
☐ ***Records of HIV/Aids testing, diagnoses or treatment*** ☐ ***Mental Health records*** ☐ ***Genetic Testing. (Check all that apply).***

I acknowledge that I have the right to revoke this authorization. I understand that my revocation must be in writing. I also understand that my revocation will be valid except to the extent that the person(s) or organization(s) authorized to make the requested use/disclosure have taken action in reliance on this authorization or 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 I have the right to inspect and copy my information that will be used or discussed pursuant to this authorization.

Patient's Signature: _____ **Date:** _____

Signature of Minor (12-17 inclusive): _____ **Date:** _____
(mental health and emancipated minor)

Parent/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.

Under the provisions of HIPAA and under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, authorization for use/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. Information is protected under Illinois Law and 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 one year after the date of signing if no prior notice for revocation is received. All original films must be returned in 15 days. I have requested above to be sent to the *facility/person named herein and that it not be further disclosed or used for any purpose other than as stated in this authorization. Any person who discloses mental health records and communication without proper consent/authorization may be subject to civil liability or criminal penalty according to 740 IL CS 110.*

Northwest Community Hospital
Northwest Community Day Surgery Center
Northwest Community Medical Group
Phone: 847.618.4950
Fax: 847.618.3249

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AUTHORIZATION FOR USE or DISCLOSURE OF INFORMATION