Occupational Health Services
Northwestern Medical Group
northwesternmedicine.org

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Name: _____ **Birth Date:** _____

Email: _____ **Phone Number:** _____

Address: _____ **City, State, Zip:** _____

RECORDS TO BE RELEASED FROM:

☐ **Northwestern Medical Group**
Occupational Health Services

RECORDS TO BE RELEASED TO:

I hereby authorize Northwestern Medical Group to release information to:

Agency/Facility/Person Name: _____

Phone Number: _____ **Fax Number:** _____

Address: _____ **City, State, Zip:** _____

I request that records be sent via: ☐ **Fax** ☐ **US Mail** ☐ **Email** ***Turnaround time for requests is 7-10 business days.***

INFORMATION TO BE RELEASED

☐ Employee Health Summary	☐ Immunization History	☐ Clinical Notes	☐ Work Capacity Reports
☐ Radiology Reports	☐ Diagnostic Imaging Films	☐ Other:	
Concerning the care of the above patient between these dates: _____ AND _____			

The information being released may contain sensitive health information regarding topics such as mental health, substance abuse, or HIV/AIDS. Such information will be released unless checked below:

☐ Mental Health ☐ Substance Abuse ☐ HIV/AIDS ☐ Other: _____

This information is being requested for the purpose of:

☐ Continuity of Care ☐ Attorney/Client Relationship ☐ Insurance ☐ At the request of the patient

PATIENT CONSENT

I understand that I have the right to inspect the disclosed information and may revoke this authorization at any time in writing except to the extent that records have already been released. In the event that written revocation of this consent is not made, this authorization will automatically expire in (6) months unless expiration date is otherwise amended. I understand that all radiology films will be returned to the hospital unless purchased as my own property.

_____ _____ _____

Signature: Patient or Legal Representative **Relation to Patient** **Date**

The Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, state that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient. The Federal Confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug and alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information does NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR41997. Nov. 2, 1987]

PLEASE SEND COMPLETED FORM TO THE FOLLOWING OFFICES FOR REVIEW:

Downtown Location	West Regions	North/Northwest Region	South Region
• Northwestern Memorial Hospital (NMH)	• Central DuPage Hospital (CDH) • Delnor Hospital • Marianjoy Rehab Hospital • Kishwaukee Hospital • Valley West Hospital	• Northwestern Medicine McHenry Hospital • Northwestern Medicine Huntley Hospital • Northwestern Medicine Woodstock Hospital • Northwestern Lake Forest Hospital (NLFH)	• Palos Hospital
Email: NMPGCH@nm.org **Fax:** 312-926-1787	**Email:** NMOccHealth@nm.org **Fax:** 630-933-5289	**Email:** OccHealthNWR@nm.org **Fax:** 815-363-0136	**Email:** OHSPalos@nm.org **Fax:** 708-923-8579