NORTHSHORE INTEGRATIVE HEALTHCARE

Phone and Fax: 847-920-4NIH (4644)
www.NorthshoreIntegrativeHealthcare.com

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Patient Name_____ Phone Number_____ Medical Record Number_____

Address_____ Birth Date _____

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person/Institution_____

Address_____

City_____State_____Zip_____

TO: Person/Institution_____

(**Recipient**) Address_____

City_____State_____Zip_____

Purpose or need for information:_____

Disclosure will include: (*check all that apply*)

☐ Face Sheet	☐ History & Physical	☐ Laboratory Report	☐ Operative Report	☐ Itemized Bill
☐ Discharge Summary	☐ Progress/Physician Notes	☐ X-ray/Radiology Report	☐ Pathology Report	☐ Other _____
☐ Emergency Report	☐ Nurses Notes	☐ EKG/EMG/EEG Report	☐ Consultation Report	

Records for the period (dates) from _____to_____

I must check one or more of the following types of health information that I do not want released to the above named Recipient.
I understand that if I do not check any of the four (4) following boxes, the health information released to the named Recipient may include any of the following:

_____ Psychiatric/mental health and/or developmental disabilities information (Parent/guardian co-signature is required for the release of psychiatric information of patients 12-17 years old)

_____ Records of HTLV-III and/or HIV (AIDS/related illness) testing results, diagnosis, or treatment

_____ Genetic Testing

_____ Alcohol/drug abuse diagnosis or treatment

I also understand that this authorization is subject to revocation/withdrawal by me at any time in writing to the Director of Medical Records except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked, but **will expire 1 year after date signed**. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information, except in instances defined in THE NOTICE OF PRIVACY PRACTICES. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others. I understand that there may be copying and/or processing fees associated with this release, such pricing to be disclosed to me upon my request.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Legal Guardian/Personal Representative Relationship to Patient

_____
Witness

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization and the recipient named above that this health information disclosed under this Authorization may be re-disclosed by the recipient to others. Federal law, rules and regulations prohibit the recipient from further disclosing any health information that may be included regarding treatment for drug/alcohol abuse.