Northwestern Health Sciences University

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

Patient Information

Name: _____ Date of Birth: _____

Address: _____ Primary Phone: _____

City: _____ State: _____ Zip: _____ Mobile/Work: _____

Information Requested or to be Released

☐ Imaging studies
☐ Complete Medical Records (including Lab and Radiology reports)
☐ Date range for requested records ____/____/____ to ____/____/____

☐ Other (Specify) _____

Purpose for Request or Release

☐ Coordination/Continuation of Care
☐ Insurance
☐ Legal
☐ Diability
☐ Personal
☐ Other

☐ Request From

Name: _____

Address: _____

Phone: _____ Fax: _____

City: _____ State: _____ Zip: _____

☐ Release To

Name: _____

Address: _____

Phone: _____ Fax: _____

City: _____ State: _____ Zip: _____

Disclosure Statements

I understand that this authorization will be in effect for 12 months unless cancelled by me in writing. The cancellation will take effect when the provider receives my notice in writing. I understand that once information is disclosed by a provider that the disclosed information may no longer be protected by privacy laws.

Authorization

I authorize the above provider to release the information marked above to the requestor:

_____ _____ _____

(SIGNATURE) **(PRINT NAME)** **(DATE)**

PATIENT|GUARDIAN