Health Service Northwestern University
633 Emerson Street
Evanston, Illinois 60208-4000
Phone 847-491-8100
Fax 847-491-8699

Northwestern
HEALTH SERVICE

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Requests for Mental/Behavioral Health records MUST be made through Counseling and Psychological Services, please call 847-491-2151.

Patient Name (Please Print) _____ Date of Birth _____

Name as a student (if different than above)_____ Student ID _____ Year Entered NU _____

E-mail _____ Phone _____

PLEASE RELEASE THE FOLLOWING HEALTH INFORMATION:

CHECK OFF EACH ITEM TO BE RELEASED. Requests for HIV/AIDS and/or Alcohol/Drug records require that you initial below.
Be as specific as possible:

_____X-Ray Report
_____X-Ray Film – Charge applies
_____TB Test Result
_____Immunizations – Specify from Evanston or Chicago campus record:_____
_____Physical Examination
_____Lab Report(s) – List type of report(s) or approximate date(s):_____
_____Visit Note(s) – List approximate dates: _____
_____Other (specify): _____

_____ Initial for release of **Alcohol/Drug** record
_____ Initial for release of **HIV/AIDS** record

_____**ENTIRE HEALTH RECORD - $25.00 Charge applies unless sent to another healthcare provider.**

Reason for requesting information (e.g. further care, insurance claim, etc.): _____

I AUTHORIZE THE HEALTH SERVICE TO RELEASE MY HEALTH INFORMATION TO (Recipient):

NOTE: If authorizing release to multiple recipients, a separate form must be submitted for each recipient.

Name _____ Phone (Required for fax requests)_____

Address _____Fax _____

City _____ State _____ Zip Code _____

Check ONE box below to identify how you want your health information released to the recipient:

☐ **Mail** ☐ **Fax** ☐ **Phone/Verbal** ☐ **Hold for Pick Up -** When records are ready, notify me by: ___E-mail ___Phone

☐ **Encrypted E-Mail to**: _____ (please print clearly)

MAIL THIS FORM TO: Northwestern University Health Service, Health Information Management Services, 633 Emerson Street, Illinois 60208-4000 ***OR FAX TO:*** 847-491-8699

***A $25.00 CHARGE APPLIES FOR A COPY OF AN ENTIRE HEALTH RECORD UNLESS SENT TO ANOTHER HEALTHCARE PROVIDER. PAYMENT MUST BE MADE PRIOR TO RECORDS BEING RELEASED. CHECKS SHOULD BE MADE PAYABLE TO** *NORTHWESTERN UNIVERSITY*.

REQUESTS ARE PROCESSED WITHIN 3-5 BUSINESS DAYS OF RECEIPT.

Call 847-491-2142 if you have questions about your release.

NOTICE TO PATIENT

I fully understand that my medical record and health information for the above date may contain alcohol/drug abuse, and/or Acquired Immune Deficiency Syndrome/HIV test results and/or mental health information and/or other information. I understand that any of the above selected records may contain medical information from outside sources and authorize NUHS to release these records and health information if necessary for continuity of care or if I have requested my complete record. I understand that I have the right to inspect and/or obtain a copy, (for the appropriate fee) of my medical record prior to disclosure. I understand that this consent applies both to written and verbal release of information and is valid for 90 days from the date of signature, or until calendar date _____. I understand that I may revoke this consent at any time by giving written notice to Health Information Management Services of Northwestern University Health Service. I absolve Northwestern University and its agents or employees from any legal liability which may arise from the disclosure of this information.

_____ _____
Signature of patient or authorized legal guardian Date

_____ _____
Relationship to patient, if signed by authorized representative Date

_____ _____
Signature of staff member who received form at NUHS Date

For Office Use Only

Number of pages _____ Date sent/initials _____ Date ready for pick-up_____