Northwestern University • Office of the Registrar
Health Information Management Services
633 Emerson Street | Evanston, IL 60208-4000
Phone: (847) 491-2117 | Fax: (847) 491-8699

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

If authorizing release to multiple recipients, a separate form must be used for each one

Patient Name (PLEASE PRINT) ______________________ **Date of Birth** ______________

Name as a student (if different than above) ______________________ **Student ID (*no letters*)** __________ **Year Entered NU** ______

E-mail ______________________ **Phone** ______________

CHECK OFF EACH ITEM TO BE RELEASED

☐ Immunizations: ______________________

☐ TB Test Results: ______________________

For records *before* December 13, 2021, select from below:

☐Lab Report(s) - List type of report(s) or approximate date(s): ______________________
☐Physical Examination / Visit Note(s) – List approximate date(s): ______________________
☐X-Ray Report(s): ______________________
☐HIV/AIDS and/or Alcohol/Drug record(s): ______________________
☐Other (specify): ______________________
☐**ENTIRE HEALTH RECORD** - $25.00 Charge applies unless sent to a healthcare provider. **Payment must be made prior to records being released.**

Credit card payments: please visit: https://nuregistraroff2.securepayments.cardpointe.com/pay
Checks should be made payable to: NORTHWESTERN UNIVERSITY, OFFICE OF THE REGISTRAR, HEALTH INFORMATION MANAGEMENT SERVICES

Reason for requesting information (e.g. continuity of care, self-records, etc.): ______________________

I AUTHORIZE NU Health Information Management Services TO RELEASE MY HEALTH INFORMATION TO:

Name (PLEASE PRINT) ______________________ **Phone (required for faxes)** ______________
Address (PLEASE PRINT) ______________________ **Fax number** ______________
City ______________________ **State** __________ **Zip Code** __________

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

☐ **Encrypted E-Mail** to (PLEASE PRINT CLEARLY): ______________________

☐ Mail ☐ Hold for Pick Up — When records are ready, notify me by: ☐ E-mail ☐ Phone

☐ Fax ☐ Phone/Verbal

REQUESTS ARE PROCESSED WITHIN 3-5 BUSINESS DAYS OF RECEIPT

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 NUHIMS Date

For Office Use Only ______________________

Number of pages Date sent/initials Date ready for pick-up

Revised 07/24