Northwestern University • Office of the Registrar
Immunization Compliance
633 Emerson Street | Evanston, IL 60208-4000
Phone: (847) 491-2117 | Fax: (847) 491-8699
Email : Immunizations@northwestern.edu

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

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

Student Name (PLEASE PRINT) _____ **Date of Birth** _____

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

E-mail _____ **Phone** _____

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

CHECK OFF EACH ITEM TO BE RELEASED

☐ Immunizations / Immunization titers / TB test results: _____

For records *before* December 11, 2021, select from below:

☐ Other (specify) : _____

☐ **ENTIRE HEALTH RECORD** - $25.00 Charge applies unless sent to a healthcare provider.
Payment must be made prior to entire health record 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, IMMUNIZATION COMPLAINCE

I AUTHORIZE IMMUNIZATION COMPLIANCE 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 to release your health information 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 3-15 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 Immunization Compliance 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 Immunization Compliance of Northwestern University. 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

_____ _____
Initials of staff member who received form at NU-Immunization Compliance Date

For Office Use Only

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

Revised 06/26