

# NORTHWESTERN ORTHOPAEDIC INSTITUTE, LLC

Record requests are processed by our copy service **Health Port** on the Wednesday of each week. The usual fee is \$30.00 for **Chart records PLUS any applicable Per page costs and taxes.** Any Xray records are extra. ALL fees apply unless sent directly to another Doctor or medical facility.

Patient Name \_\_\_\_\_  
Must Have Full Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize the protected health information regarding the above named person be released:

**FROM** Person/Institution: Northwestern Orthopaedic Institute/ Dr. \_\_\_\_\_  
Address 680 N. Lake Shore Drive , Suite 924 , Chicago, IL 60611

**TO:** Person/Institution: \_\_\_\_\_ **(Or Self)** \_\_\_\_\_  
RECIPIENT Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
**Tel:** \_\_\_\_\_ **Fax** \_\_\_\_\_

Purpose or need for information: \_\_\_\_\_  
(continuing care, Legal proceeding, Insurance, ETC)

**For records being picked up, you must indicate the date/time of pickup:** \_\_\_\_\_  
(we do not copy and call you for pick up)

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

Progress/Physician Notes     Surgical Report     Discharge Summary     Laboratory Reports  
 MRI/CT/US Report     X-ray CD (additional \$10 fee)     EKG/EMG/EEG Report  
 Radiology report     MRI Films    Other \_\_\_\_\_

Records for the period (dates) from \_\_\_\_\_ to \_\_\_\_\_

**I UNDERSTAND that my records are protected under Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law. I FURTHER UNDERSTAND THAT THIS SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED MAY, IF APPLICABLE, INCLUDED: DIAGNOSIS, PROGNOSIS, AND TREATMENT FOR PHYSICAL OR PSYCHIATRIC ILLNESS, OR TREATMENT FOR ALCOHOL OR SUBSTANCE ABUSE, OR HIV TESTING.**

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release this information. This Authorization shall remain valid but will expire in 1 year after signing. 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. 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 others. REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that Northwestern Orthopaedic Institute cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian/Personal Representative  
(Required if Patient is not legally authorized to sign Authorization)

\_\_\_\_\_  
Relationship to Patient

Release of Information Department Northwestern Orthopaedics Institute Chicago and Glenview, IL  
Please send all responses to the Chicago address below.

312-475-5534 Tel  
680 N Lake Shore Drive, Suite 924, Chicago IL 60611

312-255-1601 Fax  
2501 Compass Rd, Suite 125, Glenview IL 60026