

NOL NORTHWESTERN ORTHOPAEDIC INSTITUTE, LLC

The usual fee for chart records is a per page fee plus any applicable handling fees and postage. Any X-ray CD's are extra. ALL fees apply unless records are sent directly to another doctor or medical facility. You will be invoiced for the fees and pre-payment is required. IME reports may only be obtained from your adjustor or via a Subpoena.

Patient Name _____
Must Have Full Address _____
City, State, Zip _____
Phone Number(s) _____
Date of Birth _____

Verification of Patient Identification
Verification performed: ___ YES ___ NO
Type: _____

Verification Of Recipient Identification
Verification Performed: ___ YES ___ NO
Type: _____

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I, _____, hereby request access to and/or copies of my Protected Health Information contained in my designated record set.

FROM: 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: _____
Telephone: _____ Fax: _____

Purpose or need for the information: _____
(i.e. 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 pickup)

Disclosure will include: (check all that apply)

____ Progress/ Physician Notes ____ Surgical Report ____ Discharge Summary ____ Laboratory Results
____ MRI/CT/US Report ____ X-ray CD (additional \$10 fee) *Report not included* ____ EKG/EMG/EEG Report
____ X-ray Report ____ Physical/Occupational Therapy Notes ____ 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, INCLUDE: 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 taken to release this information. This Authorization shall remain valid but will expire in 1 year after signing it. 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 to 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

Recipient of Information (when appropriate) Signature

Date

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

TEL: 312-475-5534

FAX: 312-255-1601

680 N. Lake Shore Drive, Suite 924 Chicago, Il. 60611

2501 Compass Road, Suite 125 Chicago, Il. 60611