0000-106

NorthShore University HealthSystem

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

0000-106 (1/2016)

You may email your completed form to releaseforms@northshore.org
Or, request your medical records through *NorthShoreConnect*

Patient Name _____ Date of Birth _____

Street Address _____ City _____ State ____ Zipcode _____

Phone _____

I AUTHORIZE NORTHSHORE UNIVERSITY HEALTHSYSTEM TO RELEASE TO:

Name RECORDS DEPOSITION SERVICE, INC.

(If an individual, describe the relationship to the patient)

Street Address PO BOX 5054 City SOUTHFIELD State MI Zip Code 48086-5054

Phone 248-357-3330 Fax 248-357-3337

I wish records to be sent: Disc (CD) _____ Paper _____ Secure Email INFO@RECDEP.COM

(Please provide email address)

THE FOLLOWING INFORMATION FROM THE ABOVE NAMED PATIENT'S RECORD

Please check off appropriate box(es):

- _ Hospital Records (Abstract)
- _ Emergency Room Record
- _ Lab Test Results
- _ Radiology Report __ Radiology film (images)
- _ Outpatient Therapy Note
- _ Office Visit (Doctor)_____
- ✓ Other PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

Please initial specific areas to release sensitive information

- — Psychiatric Records
- — HIV results
- — Drug/Alcohol Records
- — Neurology Records
- — Other _____

Approximate dates of Service _____

Purpose/need for information (specify the use of the information to be disclosed): PRE TRIAL DISCOVERY

THE FOLLOWING STATEMENT APPLIES ONLY TO RECORDS RELATING TO PSYCHIATRIC TREATMENT

I understand that my refusal to authorize disclosure of the above-mentioned information will prevent disclosure of the information. The consequences of refusal to authorize may include incomplete diagnostic evaluation, recommendations or treatment. Additional consequences of refusal to authorize may be: (If applicable)_____

Signature of patient or authorized legal guardian date

Relationship to patient, if signed by authorized representative OR Authorized Relative Certificate (attached) date

Signature of witness (if applicable) date

NOTICE TO PATIENT I understand that this consent is valid for 90 days from the date of signature, or until calendar date ____/____/____. I understand that as set forth in NorthShore University HealthSystem notice of Health Information practices, that I may revoke this authorization at any time by giving written notice to the Medical Record Department of the NorthShore University HealthSystem except to the extent that NorthShore University HealthSystem has already acted in reliance on this contract. This authorization will automatically expire when the information requested has been disclosed, if I have given no prior notice as stated above. I understand I have the right to review and obtain the information to be disclosed. I understand that information disclosure pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. For psychiatric, psychological and social work records, Release of Information regulations as stated in the Illinois Mental Health Confidentiality Act will take precedence.