Name of Patient:		Social Security Number:		Birth date:
Address of Patient:	City, State, Zip		Age:	Telephone Number

AUTHORIZATION IS GIVEN BY UNDERSIGNED TO RELEASE THE INFORMATION SPECIFIED BELOW:

❒To ❒From	**Name of Organization or Person to RELEASE Information:** NorthShore Health Centers PO Box 1430 City: Portage State: IN Zip: 46368 Phone: 219-763-8112 **Portage Fax:** 219-764-5333 **Lake Station Fax**: 219-962-1863 **Merrillville Fax:** 219-884-2582 **Hammond Fax:** 219-844-9099 **Chesterton Fax:** 219-763-8937
❒To ❒From	

THE INFORMATION IS REQUESTED FOR THE FOLLOWING PURPOSE:
❒ Continuing medical care
❒ Claim for reimbursement
❒ Litigation against third party other than (COVERED ENTITY) employee, or physician (Specify):
❒ Litigation against third party other than (COVERED ENTITY), a (COVERED ENTITY) employee, or a physician (Specify)

____

❒ At the patients request
❒ Other (Specify) ____

I understand that this authorization can be revoked by me at any time by submitting a written request to.
I understand that revocation will not apply if (COVERED ENTITY) has already released by information.
I understand that (COVERED ENTITY) cannot require me to sign this authorization as condition for providing treatment obtaining payment for same.
I understand that the material released as a result of this authorization may be subject to re-disclosure and no longer protected by the laws applying to medical information release.

The authorization will expire as follows:

Dates:	I specifically authorize the release of information relating to:
❒ History & Physical exams: ________________ ❒ Progress Notes: ________________ ❒ Lab reports: ________________ ❒ X-ray reports: ________________ ❒ Other: ________________	❒ Substance abuse (including alcohol/drugs) ❒ Mental Health (including psychotherapy notes) ❒ HIV related information (AIDS related testing) ______________________________ ________________ Signature of patients or legal guardian Date

❒Purpose of disclosure: ❒Changing Physicians ❒Consultation/second opinion ❒ Continuing care

____ ________________________________
(Signature of Patient) (Date Signed)

____ ________________________________
(Signature of Other Authorized Person) (Relationship to Patient)

Authorization must be signed by the parent or legal guardian of any patient under 18, the legal guardian of any patient under guardianship, the personal representative of a deceased patient, or if no personal representative the spouse or adult child of deceased patient. If patient is under 18 and records are protected by Federal Law (42 CFR part 2) regarding drug or alcohol abuse, authorization must be signed by both patient and parent or legal guardian. Emancipated minors may sign for self. Revised 2/13