Authorization to Disclose Protected Health Information

Release Information **To** or **Receive From**

Address Fax Number

Release Information **To** or **Receive From** NorthShore Health Centers

NorthShore Location Fax Numbers (select a location):

Portage Health Center (219) 764-5397
Stacy McKay Health Center (219) 962-5090
Hammond Health Center (219) 850-1228
LaPorte Health Center (219) 763-8934
Demotte Health Center (219) 962-5409
St. John Convenience Center (219) 962-4516
Chesterton Health Center (219) 763-8938
Lake Station Health Center (219) 962-1863
Merrillville Health Center (219) 764-5362
Lake Station Dental Center (219) 962-1189
Crown Point Convenience Center (219) 962-5367
Schererville Convenience Center (219) 962-1792

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.
Identifying information at the time of service:

Patient's Full Name

Maiden or Other Name Date of Birth

Last 4 Number of Social Security Number Phone Number

Address

Covering periods of treatment

All Dates of Service Or for the specific period of (Date) To (Date)

1. Information authorized for disclosure, if included in my records:
   Complete Health Record
   Dental Records
   Patient Plans
   History and Physicals
   Progress Notes
   Immunization Records
   Radiology and Diagnostic Imaging Reports
   Photographs, Videos, Digital or Other Images *(On CD)*
   Pathology Reports
   Laboratory Tests
   Other ______________________________

2. If applicable, I also give permission for the following areas of Sensitive Protected Health information to be disclosed *(please check the appropriate boxes).*
   - Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
   - Behavioral Health Services / Psychiatric Care
   - History and Treatment for Alcohol and/or Drug Abuse

3. Manner in which my protected health information is to be disclosed *(please check the appropriate boxes).*
   Records on paper Records on CD Faxed

4. Purpose for Disclosure *(please check one).*
   - Personal
   - Legal
   - Transfer of Care
   - Coordination of Care
   - Insurance
   - Other, specify:

5. I understand that:
   - I have the right to revoke this authorization at any time, unless NorthShore Health Centers has already released the information on reliance of my previous consent. My consent may be revoked by submitting a written and dated notice of revocation to NorthShore Health Centers.
   - This authorization will expire on *(Date).*
   - If no expiration date is provided this authorization will be valid for (60) days from the date signed below.
   - Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy standards.
   - 42 CFR Part 2 and/or HIPAA 45 CFR prohibits further re-disclosure of records related to substance and alcohol abuse and treatment.
   - I will not be denied treatment, payment, enrollment, or eligibility for benefits based on signing this Authorization.
   - NorthShore Health Centers, its employees, officers, and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the information indicated above and authorized herein.

Signed: Patient – *(or Legal Representative, Parent, or Legal Guardian)* *(Relationship if not Patient)*

Date