



PATIENT INFORMATION			
Last Name:	First:	M.I.:	Date:
Phone:	D.O.B:	SS #:	
Home Address:			
City:		State:	Zip Code:
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION			
I authorize the custodian of records from:			
<input type="checkbox"/> Northshore Center for Gastroenterology <input type="checkbox"/> Other _____			
to disclose/release the following information from the following dates _____			
for the following records: (Check all applicable below).			
<input type="checkbox"/> All Records	<input type="checkbox"/> Progress Notes / History and Physical / Summary		
<input type="checkbox"/> Laboratory / Pathology Records	<input type="checkbox"/> Pharmacy / Prescription Records		
<input type="checkbox"/> X-Ray / Radiology Records	<input type="checkbox"/> Other:		
<input type="checkbox"/> Billing Records			
Please send records to:			
Name:		Phone:	
Address:			
City:		State:	Zip Code:
PATIENT/GAURDIAN SIGNATURE			
By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.			
Signature:			Date:

Copying Fees: If you are requesting disclosure/release of health information from Northshore Center for Gastroenterology to other hospitals, clinics, or physicians for further medical care, no copying fees will be charged.

PLEASE FAX OR MAIL RECORD RELEASE TO:

Northshore Center for Gastroenterology
1880 W. Winchester Rd Suite 201
Libertyville, IL 60048
Phone: (847) 247-0187
Fax: (847) 247-0487