NSG Northshore Center for Gastroenterology

Medical Records Release

Patient Information:			
Last Name:	First:	M.I.:	Date:
Phone:	D.O.B:	SS #:	
Home Address:			
City:	State:	Zip Code:	

Authorization for use or disclose of protected health information

I authorize the custodian of records from:

☐Northshore Center for Gastroenterology ☐Other _____

to disclose/release the following information from the following dates_____

for the following records: (Check all applicable below).

- ☐ All Records
- ☐ Laboratory / Pathology Records
- ☐ X-Ray / Radiology Records
- ☐ Billing Records
- ☐ Progress Notes / History and Physical / Summary
- ☐ Pharmacy / Prescription Records
- ☐ Other:

Please send records to:

Name:	Phone:
Address:	
City:	State: Zip Code:

Patient/Guardian 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 may apply and are ultimately the responsibility of the Guarantor.

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