



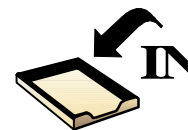
Northwestern Internists, Ltd.

GENERAL INTERNAL MEDICINE

ADULT PRIMARY CARE

Beverly Calub, MD
Cathie Gantern, MD
John Glynn, DO
Samuel Granieri, MD
Gary Gruber, MD
Amy Kissinger, MD

Jason Primer, MD
Ellen Ross, MD
Beth Royston, MD
Michael J. Stewart, MD
Mark W. Stolar, MD
Anna f. Wu, MD



Authorization For Release Of Information

(Please Print All Information)

I, \_\_\_\_\_
First Name M.I. Last Name

Address: Street City / State / Zip

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_-\_\_\_-\_\_\_
Month Day Year

Daytime Phone number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Insurance Name & Plan (HMO or PPO): \_\_\_\_\_

hereby authorize and request that:

Provider Name: \_\_\_\_\_

Address: Street City / State / Zip

Provide and copy of my medical records to:

Northwestern Internists, Ltd.
676 N. Saint Clair St., Suite 415
Chicago, IL 60611
Phone: (312) 335-1133
Fax: (312) 335-9774

all information in my medical record EXCLUDING (Please specify by checking appropriate line):

- History & Physical
Progress Notes
Diagnostic Reports
Operative Reports
Other (Specify):
HIV Testing and Treatment Information
Mental Health Records
Alcohol & Drug Abuse Records

I understand that this Authorization will expire in six months, on \_\_\_/\_\_\_/\_\_\_

X \_\_\_\_\_
Signature of Patient Date

X \_\_\_\_\_
Signature of Legal Representative (if applicable) Legal basis on which consent is given by Representative

X \_\_\_\_\_
Witness