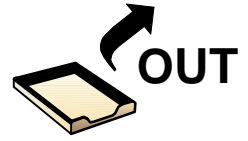


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Northwestern Internists, Ltd.
GENERAL INTERNAL MEDICINE
ADULT PRIMARY CARE



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: (____) _____ - _____

hereby authorize and request **Northwestern Internists, Ltd.** to provide to:

Receiving Organization/Agency/Person _____

Address: Street _____ City / State / Zip _____

The following fees apply to record requests other than for the purpose of Transfer of Care and follow-up care with Specialist:

(\$15) 1-2 yrs.	(\$25) 3-5 yrs.	(\$45) 6+ yrs.
-------------------------	------------------------	-----------------------

Requesting Records Period: From: (mo)____/(yr)____ To: (mo)____/(yr)____

Please specify:

- | | |
|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> HIV Testing and Treatment Information |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Mental Health Records |
| <input type="checkbox"/> Diagnostic Reports | <input type="checkbox"/> Alcohol & Drug Abuse Records |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Entire Chart |
| <input type="checkbox"/> Other (Specify): _____ | |

I understand that I have the right to inspect and copy the information to be disclosed.

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

I understand that I may revoke this authorization at any time by notifying **Northwestern Internists, Ltd.** in writing, but if I do it won't have any affect on any actions they took before they received the revocation.

X _____
Signature of Patient Date

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

X _____
Witness