

Place patient label here

Communication Choices

Authorization: Family and Friends Involved in My Care

By signing this authorization form, you are allowing Northwestern Medicine (“NM”)¹ to share your health information with the family and friends whom you list below and who may be involved in your care or payment for your care.

I give permission for NM to share (either verbally, in writing, by phone or through voicemail) my health information to the following individuals for purposes of my care and/or payment for care. I understand that my health information may include (if applicable to me) the following types of information: HIV/AIDS; behavioral or mental health; developmental disabilities; treatment for substance (alcohol and/or drugs) use disorder; genetic testing and counseling; artificial insemination; sexual assault/ abuse; domestic abuse of an adult with a disability, child abuse and neglect; and, if I am a minor, sexually transmitted illnesses, pregnancy and birth control.

Name	Phone Number

I have the right to withdraw (take back) this authorization at any time. My withdrawal must be in writing. Any withdrawal will not apply to information already released by NM prior to my withdrawal. For information on how to withdraw this authorization, contact the NM Health Information Management Department at 312-926-3376. If not withdrawn, this authorization is valid for a period of one (1) year from the date of signature.

Additional notices required by law:

- I understand that, once the family member or friend authorized to receive my health information has received it, the information may no longer be protected by federal privacy laws, and that person may be able to further disclose or share my health information. However, Illinois law does not allow re-release of AIDS/HIV, genetic testing, mental health or developmental disabilities information by the receivers of the information except in precise situations allowed by law. Also, Federal Confidentiality Rules, 42 CFR Part 2, prohibit making any further disclosure of drug and alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR.
- I understand that I am not required to complete this authorization form. If I choose not to complete this form, NM will still care for me.
- I understand I have the right to inspect and copy the mental health and developmental disabilities records to be released.

Patient Name/Signature (for patients age 12 or over): _____ Date: _____

Signature of Parent/Guardian/Legal Representative: _____ Date: _____

Witness Signature: _____ Date: _____

¹ Northwestern Medicine is the integrated academic health system of Northwestern Memorial HealthCare, including hospitals and physicians. NM hospital and physicians include, but are not limited to the following: Northwestern Memorial Hospital, NM Lake Forest Hospital, Northwestern Medical Group, NM Central DuPage Hospital, NM Delnor Hospital, NM Regional Medical Group, NM Kishwaukee Hospital, NM Valley West Hospital, Kishwaukee Physician Group, DeKalb Behavioral Health Foundation, Marianjoy Rehabilitation Hospital, and Rehabilitation Medicine Clinic. This list may change from time to time. For a complete listing of NM hospitals and physicians, please go to nm.org or call our main number (312-926-2000) and ask for Physician Referral Services or send an email to PhysicianReferral@nm.org.

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Communication Choices

Authorization to Leave Voicemails

By signing this authorization form, you are allowing Northwestern Medicine (“NM”)² to leave voicemails at the numbers listed below.

I give permission for NM to leave voicemails with detailed health information, including but not limited to HIV/AIDS; behavioral or mental health; developmental disabilities; treatment for substance (alcohol and/or drugs) use disorder; genetic testing and counseling; artificial insemination; sexual assault/abuse; domestic abuse of an adult with a disability, child abuse and neglect; and, if I am a minor, sexually transmitted illnesses, pregnancy and birth control.

Preferred phone number	Type (e.g., cell or home number)

I have the right to withdraw (take back) this authorization at any time. My withdrawal must be in writing. Any withdrawal will not apply to information already released by NM prior to my withdrawal. For information on how to withdraw this authorization, contact the NM Health Information Management Department at 312-926-3376. If not withdrawn, this authorization is valid for a period of one (1) year from the date of signature.

Additional notices required by law:

- I understand that, once NM has left a voicemail at the above number(s), the information may no longer be protected by federal privacy laws, and that any person retrieving the voicemail may be able to further disclose or share my health information. However, Illinois law does not allow re-release of AIDS/HIV, genetic testing, mental health or developmental disabilities information by the receivers of the information except in precise situations allowed by law. Also, Federal Confidentiality Rules, 42 CFR Part 2, prohibit making any further disclosure of drug and alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR.
- I understand that I am not required to complete this authorization form. If I choose not to complete this form, NM will still care for me.
- I understand I have the right to inspect and copy the mental health and developmental disabilities records to be released.

Patient Name/Signature (for patients age 12 or over): _____ Date: _____

Signature of Parent/Guardian/Legal Representative: _____ Date: _____

Witness Signature: _____ Date: _____

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