



NorthShore
MEDICAL GROUP

Patient Name _____

Date of Birth _____

Authorization to Communicate & Share Personal Health Information

COMMUNICATION

NorthShore Medical Group may contact me via the following methods regarding any items that assist in carrying out treatment, payment, and healthcare operations such as appointment reminders, insurance items, and calls pertaining to my clinical care, including laboratory and test results.

Please check all that apply:

Phone – NorthShore Medical Group may call my home or other designated location and leave a message on the answering machine, voice mail, or in person.

Mail – NorthShore Medical Group may send mail to my home or other designated location.

Email – NorthShore Medical Group may send email to designated email address(es).

SHARING INFORMATION WITH Other Parties

The names listed below are other parties to whom I grant permission for my health care providers and their representatives at NorthShore Medical Group to verbally discuss my care.

Name	Relationship
_____	_____
_____	_____

Minors Only

Do not release the following information to anyone, including a parent or guardian, without my written permission:

- STD testing/treatment including HIV (14 & Over)
- Birth Control & Prenatal Care (any age)
- Mental health treatment (13 & Over)
- Substance Abuse Treatment (13 & Over)

Patient Signature

Date
