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

_____ _____