AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

/ /

First Name | Last Name | Maiden/Other Name(s) | Date of Birth

( ) -

Address | Phone Number

RELEASE INFORMATION FROM

I authorize Northwestern Memorial HealthCare ("NMHC") and its clinical affiliates to release information from

MEDICAL IMAGES TO BE RELEASED

SEND INFORMATION TO

Please send my information to:

Northwestern University Dean of Student's Office, Student Affairs