Nemours

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

* 0 1 0 2 2 *

Patient Name: _____ **Date of Birth:** _____ **MR#** *(Staff to Complete):* _____

Phone: _____ **Address:** _____

I would like to receive these records via ☐Fax ☐CD ☐Paper ☐Email **Email Address:** _____

RELEASE MEDICAL RECORDS FROM:

Facility or Name: _____

Address: _____

City/ST/Zip: _____

Phone #: _____ Fax: _____

DISCLOSE MEDICAL RECORDS TO:

Facility or Name: _____

Address: _____

City/ST/Zip: _____

Phone #: _____ Fax: _____

I AM REQUESTING MEDICAL RECORDS FOR DATES:

FROM: _____ **TO:** _____ ☐ **ALL**

FEES: I understand and agree that there may be costs associated with this request in compliance with State and Federal Copying laws. _____ *(please initial)*

INFORMATION TO BE DISCLOSED *(please specify)*:

☐ I am requesting records from a specific department.
Department Name: _____

- ☐ Entire Inpatient Medical Record
- ☐ Entire Outpatient Medical Record
- ☐ Abstract of Medical Record
- ☐ Outpatient Clinic Note/Encounter
- ☐ Labs/Pathology Reports
- ☐ Pathology Slides/Blocks
- ☐ Imaging Reports (x-rays, MRI, etc.)
- ☐ Imaging Films
- ☐ Echocardiogram Tapes
- ☐ Operative Notes
- ☐ History/Physical Exam
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Medications
- ☐ Billing Statement
- ☐ Verbal Communication
- ☐ Other (specify below):

Your initials are required to release the following:

- _____ Psychiatric/Psychology Notes
- _____ Psychological Evaluations& Results
- _____ Genetics Testing
- _____ HIV Lab Reports
- _____ Drug/Alcohol Results
- _____ STD Information

Please Note: Some of these items may require signature of the minor

PURPOSE OF DISCLOSURE *(please specify)*:

☐Continuing care with another physician or hospital

☐Transfer of Care ☐Personal Copy ☐Other: _____

EXPIRATION DATE OR EVENT:

(if left blank, this Authorization expires 90 days from the date signed)

Specify a date or event:_____

AUTHORIZATION:

1. I may revoke this authorization at any time by notifying the "Sent FROM" organization noted above in writing.
2. I understand that my revocation does not affect any disclosures made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy regulations.
4. I have the right to inspect or copy the information to be used/disclosed as permitted by federal law.
5. I may refuse to sign this authorization and that it is strictly voluntary.
6. If I do not sign this form, my health care and the payment for my health care will not be affected.
7. If this authorization originated with the provider, I will receive a copy of this form after I sign it.

Patient/Guardian/ Representative Signature: _____ Date: _____

Patient/Guardian/ Representative Printed Name: _____ Relationship to Patient: _____

Instructions for Form Completion:

-Complete Patient Name, Date of Birth, Phone, and Address. The MR# section will be completed by the HIM Staff.

-Choose how you would like to receive your records by checking one of the boxes. If no box has been selected – we will mail your records to you.

-Release Medical Records From box: List the facility from where records are to be released.

-Disclose Medical Records To box: List the person/facility that should receive the records.

-I am requesting Medical Records for Dates section: Identify the specific date range for which you are requesting records. Check the All box only if you wish to receive all medical records we have on file.

-Information to be Disclosed: Please specify from which Department you are requesting records. If no specification is made, records will be sent for all departments, excluding items in box which require intials.

-Within the box below identify specific reports that you are requesting.
For Abstract of the Medical Record:

- Inpatient abstract includes: H&P, Consults, Operative Report, Diagnostic Studies, Discharge Summary, Emergency Room Report
- Outpatient Abstract includes: All progress notes for each clinical division, Key Diagnostic Studies, Emergency Room Report, Operative Reports, Discharge Summary

-Your initials are required to release the following – You will only receive copies of these types of reports if initials are present. Some of these items may require signature of the minor.

-Note: Fees are calculated per page.
Records requested for Continuing Care purposes can be sent directly to the Provider at no charge.

-Purpose of Disclosure – Please specify why you are requesting records (this section is optional).

-Expiration Date or Event – Please specify a date or event that you would like this Authorization to expire. If left blank, this Authorization will expire in 90 days.

-Please review the Authorization section, sign and print your name, enter the date, and your relationship to the patient. (if the patient is 18 years or older – they must sign the Authorization)