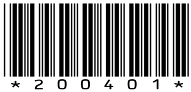

200401

AUTHORIZATION TO RELEASE/OBTAIN PATIENT INFORMATION

PATIENT INFORMATION: (please print) **Medical Record Number:** ____________________

First Name:______________________________ Middle Initial:_______ Last Name:__________________________

Name at Time of Treatment (if different than above): ____

Date of Birth: _______________ Phone: __________________ Email (optional): _____________________

Street Address: ____City: __________________ State: _____ Zip: ______

I authorize *(PROVIDER/HOSPITAL/ORGANIZATION):* ____

to RELEASE/OBTAIN *(circle one)* my/my child's protected health information including copies of my medical record of care TO/FROM *(circle one)* the following person(s) at the address/facility listed below:

Name of Person/Facility: ____

Street Address: ____City: _________________ State: _____ Zip: _______

Phone: __________________ Fax: __________________ Email (optional): ___________________________________

Please send/communicate my information by: ☐ Email ☐ CD ☐ Fax ☐ Paper ☐ Patient Portal

Information to be released: **(check all items to be released):**

Covering the period(s) of care (list applicable dates): _____________________________

Specify department(s), provider(s) *optional:* ____

☐ History and Physical, Consults, Operative Report, Diagnostic Studies, Discharge Summary, Emergency Room Report **(Inpatient Abstract)**
☐ All office visits for each clinical division, Key Diagnostic Studies, Emergency Room Report, Operative Reports **(Outpatient Abstract)**
☐ Discharge Summary ☐ Outpatient Office Visit ☐ Operative Report ☐ Imaging Report ☐ Imaging Films ☐ Lab Reports
☐ Other (please specify): ____

Your initials are required to release the following:

______ Psychiatric/Psychology Social Work Notes ______ Psychological Evaluation & Results
______ Genetics Testing ______ HIV Reports/STD Reports ______ Drug/Alcohol Results

Purpose of Disclosure (please specify as required by HIPAA regulations):

☐ Continuing Care with another physician/hospital ☐ Transfer of Care ☐ Personal Copy ☐ Other ___________________

AUTHORIZATION:

1. I may revoke this authorization at any time by notifying the originating 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. Authorization will expire 90 days after signature unless indicated otherwise (insert date): ________________
7. If I do not sign this form, my healthcare and the payment for my healthcare will not be affected.
8. If this authorization originated with the provider, I will receive a copy of this form after I sign it.

Patient/Legal Representative Signature: ____ **Date:** __________________

Patient/Legal Representative (Printed Name): _____________________________ **Relationship to Patient:** __________________

NOTICE: **There may be costs associated with this request in compliance with State and Federal laws**.
For personal copy, CD/Fax/Email/Paper: $6.50, plus applicable sales tax and postage

Email your completed form to patientrecords@nemours.org, or Fax your completed form to: 302-651-4480
For questions, please call: 866-956-7299, press option #1

AUTHORIZATION TO RELEASE/OBTAIN PATIENT INFORMATION

Instructions for Form Completion:

- Complete Patient Name, Name at Time of Treatment (if different), date of birth, phone, Email, and address. The Medical Record # section will be completed by the HIM Staff.
- RELEASE/OBTAIN Medical Records: List the facility/person that the records should be released or received.
- **Information to be released**:
    - Please list the dates of service if applicable
    - Please list the department/s or provider/s if applicable
    - Please identify the specific reports that you are requesting
    - Your initials are required to release the following: You will only receive copies of these type of reports if initials are present.
- Purpose of disclosure – Please specify why you are requesting records
- Signatures – please review the Authorization section, sign and print your name, enter the date and your relationship to the patient (if the patient is 18 or older – they must sign the Authorization).
    - NOTE: Authorization will expire in 90 days after signature unless otherwise specified *(see #6 under authorization)*.

My Nemours Patient Portal:

You may sign up for **My Nemours**, a secure, confidential and easy-to-use website that gives patients and families 24-hour access to selected parts of their medical records. This free program is designed to help patients and families easily manage and receive important health information. To get started or for more information on MyNemours, please visit us at www.Nemours.org/mynemours, or call 877-696-3668, Monday through Friday from 8:00 a.m. to 5:00 p.m EST.

Key: HIV: Human Immunodeficiency Virus; STD: Sexually Transmitted Disease