NEMOURS CHILDREN'S HEALTH

200401

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: _____

FACILITY OR INDIVIDUAL RELEASING MEDICAL RECORDS: (PLEASE NOTE: RELEASING FACILITY WILL DEFAULT TO NEMOURS IF LEFT BLANK.)				FACILITY OR INDIVIDUAL RECEIVING MEDICAL RECORDS:			

Please send medical records by:

First Choice: **CD** **Fax** **Paper** ☐ **NemoursApp** **Email** _____

Second Choice: **CD** **Fax** **Paper** **NemoursApp** **Email** _____

If the requested information is not readily producible in the selected format, a readable hard copy will be sent by mail.

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:* _____

(Inpatient Abstract
(Outpatient Abstract)

_____ _____

_____

Patient or Parent/Legal Representative Initials are REQUIRED to release the following:

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

AUTHORIZATION:

Patient/Legal Representative Signature: _____ Date: _____ TIME: _____AM/PM

Patient/Legal Representative (Printed Name): _____ Relationship to Patient: _____

TO _____ COPIES OF MEDICAL RECORDS FROM NEMOURS:	TO ____ MEDICAL RECORDS TO NEMOURS SPECIALTY CARE BY FAX:	TO ____ MEDICAL RECORDS TO NEMOURS PRIMARY CARE BY FAX:
_____ NOTICE: For Questions, please call 866-956-7299, press option #1		

NEMOURS CHILDREN'S HEALTH

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