

* 200401 * AUTHORIZATION FOR NEMOURS TO RELEASE/ OBTAIN PROTECTED HEALTH 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:		
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:	
	Facility/Name:	
Address:	Address:	
Oty/ST/Zp:	Gty/ST/Zp:	
Phone #: Fax:	Phone #:	Fax:
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 Cardiology Images Accounting of Disclosure Patient or Parent/Legal Representative 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 reg Continuing Care to Another Physician/Hospital Transfer AUTHORIZATION:	gulations):	Other
 I may revoke this authorization at any time by notifying the originating organization noted above in writing. I understand that my revocation does not affect any disdosures made prior to the revocation being received and processed. I understand the information disdosed may be subject to re-disdosure and no longer be protected by federal or state privacy regulations. I have the right to inspect or copy the information to be used/disdosed as permitted by federal law. I may refuse to sign this authorization and that it is strictly voluntary. Authorization will expire 90 days after signature unless indicated otherwise (insert date):		
Patient/Legal Representative Signature:	Date:	TIME:AM/PM
Patient/Legal Representative (Printed Name):	Relationship to Patient:	
TO COPIES OF MEDICAL RECORDS FROM NEMOURS: Fax: 302-651-4480 Email: patientrecords@nemours.org NOTICE: There may be costs associated with this request. For personal copy, CD/ Fax/ Email/ Paper: \$6.50 For Questions, please call 866-956-7299, press option #1	TO MEDICAL RECORDS TO NEMOURS SPECIALTY CARE BY FAX: ORL (407) 650-7124 PNS (850) 473-4543 DE (302) 295-0718 JAX- (904) 697-3927	TO MEDICAL RECORDS TO NEMOURS PRIMARY CARE BY FAX: DE- (302) 298-8995 ORI/CHA (321)388-0111



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