AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ____________________ Date of Birth: ____________ MR# (Staff to Complete): ____________

Phone: ____________________ Address: ____________________

RELEASE MEDICAL RECORDS FROM:	DISCLOSE MEDICAL RECORDS TO:
Facility or Name: ____________	Facility or Name: **Dr. Michael Bober / Angie Duker** **A.I. duPont Hospital for Children** **Division of Medical Genetics**
Address: ____________	Address: **1600 Rockland Road** **Wilmington, DE 19803**
City/ST/Zip: ____________	City/ST/Zip: ____________
Phone #: ____________ Fax: ____________	Phone #: **302-651-5916** Fax: **302-651-5033**

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.

INFORMATION TO BE DISCLOSED *(please specify)*:

☐ Entire Inpatient Medical Record
☐ Entire Outpatient Medical Record

OR select specific reports below:

☐ Abstract of Medical Record
☐ Outpatient Clinic Note/Encounter
☐ All Diagnostic Test Results
☐ Labs
☐ Imaging Reports (x-rays, MRI, etc.)
☐ Pathology Reports
☐ Operative Notes
☐ History/Physical Exam
☐ Discharge Summary
☐ Consultation Reports
☐ Medications
☐ Billing Statement
☐ Other (specify below):

Your initials are required to release the following:

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

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: ____________

Witness Signature: ____________________ Date: ____________