Nemours

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

0 1 0 2 2

(Please refer to Form Completion Instructions)

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

Phone: _____ **Address:** _____

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

RELEASE MEDICAL RECORDS FROM:

Facility or Name: _____

Department: _____

Address: _____

City/State/Zip: _____

Phone #: _____ Fax: _____

DISCLOSE MEDICAL RECORDS TO:

Facility or Name: _____

Department: _____

Address: _____

City/State/Zip: _____

Phone #: _____ Fax: _____

I AM REQUESTING MEDICAL RECORDS FOR DATES: FROM: _____ TO: _____

- ☐ Abstract of Medical Record
- ☐ Outpatient Clinic Note/Encounter
- ☐ Labs/Pathology Reports
- ☐ Pathology Slides/Blocks
- ☐ Imaging Reports (x-rays, MRI, etc.)
- ☐ Imaging Films
- ☐ Echocardiogram Tapes
- ☐ Electrocardiogram
- ☐ Verbal Communication with Health Professional
- ☐ Operative Notes
- ☐ History/Physical Exam
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Medications
- ☐ Photos
- ☐ Billing Statements
- ☐ Appointments/Scheduling
- ☐ Other (specify below): _____

Your initials are required to release the following:

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

Please Note: If requesting an Adolescent Encounter, the signature of the minor is required _____

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: _____

THIS SECTION TO BE COMPLETED ONLY WHEN AUTHORIZING OTHER INDIVIDUALS ACCESS TO MY PROTECTED HEALTH INFORMATION

☐ I am requesting that the following individual(s) have my permission to inquire about my appointments, have access to the medical information listed above, and receive detailed information regarding my treatment:

Name: _____ Relationship: _____ Name: _____ Relationship: _____

Name: _____ Relationship: _____ Name: _____ Relationship: _____

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.

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

Patient/Legal Representative Signature: _____ Date: _____

Patient/Legal 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.
- Within the box below identify specific reports that you are requesting.
- For an **Abstract** of the Medical Record:
  - Inpatient abstract includes: History and Physical, 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. If requesting an adolescent encounter, the signature of the minor is required.
- Purpose of Disclosure – Please specify why you are requesting records.
- 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.
- Within the section authorizing other individuals to have access to protected health information, please list the person's name and relationship to the patient (example use this section for: Patients over 18 granting parent access to Protected Heath Information)
- 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).
- Note: Fees are calculated per page.
  Records requested for Continuing Care purposes can be sent directly to the Provider at no charge.

Fax your completed form to:

Delaware Valley: (302) 651-4480
Jacksonville, FL: (904) 697-3692
Pensacola, FL: (850) 505-4710
Nemours Children's Hospital, FL: (407) 650-7121

Email your completed form (for any location) to: patientrecords@nemours.org

Key:
MRI: Magnetic Resonance Imaging
HIV: Human Immunodeficiency Virus
STD: Sexually Transmitted Disease