Nemours

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION
(MULTIPLE REQUESTS)

01022-1

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

Phone: _____ Address: _____

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

RELEASE MEDICAL RECORDS FROM:

Facility or Name: A. I. DuPont Hospital for Children

Address: 1600 Rockland Road

City/ST/Zip: Wilmington, DE 19803

Phone #: 302-651-4431 Fax: 302-651-4480

DISCLOSE MEDICAL RECORDS TO:

Facility or Name: CLarke Schools for Hearing and Speech

Address: 455 S Roberts Road

City/ST/Zip: Bryn Mawr, PA 19010

Phone #: 610-525-9600 Fax 610-525-9655

☐ (See page 2 for additional Disclosures)

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. _____ *(please initial)*

INFORMATION TO BE DISCLOSED *(please specify)*:

☒ I am requesting records from a specific department.

Department Name Outpatient Therapy Services/ Otolaryngology

- ☐ Entire Inpatient Medical Record
- ☐ Entire Outpatient Medical Record
- ☐ Abstract of Medical Record
- ☐ Outpatient Clinic Note/Encounter
- ☐ Labs/Pathology Reports
- ☐ Pathology Slides/Blocks
- ☐ Imaging Reports (x-rays, MRI, etc.)
- ☐ Imaging Films
- ☐ Echocardiogram Tapes
- ☐ Operative Notes
- ☐ History/Physical Exam
- ☐ Discharge Summary
- ☒ Consultation Reports any & all
- ☐ Medications
- ☐ Billing Statement
- ☐ Verbal Communication
- ☒ Other (specify below):

Audiograms any & all

Your initials are required to release the following:

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

Please Note: Some of these items may require signature of the minor

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: _____