


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: _____ Email (optional): _____

Street Address: _____ City: _____ State: _____ Zip: _____

FACILITY RELEASING MEDICAL RECORDS:			FACILITY RECEIVING MEDICAL RECORDS:		
Facility or Name:			Facility or Name:		
Address:			Address:		
City/ST/Zip:			City/ST/Zip:		
Phone #:	Fax:		Phone #:	Fax:	

 Please send medical records by: ☐ CD ☐ Fax ☐ Paper ☐ NemoursApp ☐ Email _____

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 ☐ Other (please specify): _____

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 regulations):
☐ Continuing Care with another physician/hospital ☐ Transfer of Care ☐ Other _____

AUTHORIZATION:

- 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 disclosures made prior to the revocation being received and processed.
- I understand the information disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy regulations.
- I have the right to inspect or copy the information to be used/disclosed 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): _____
- If I do not sign this form, my healthcare and the payment for my healthcare will not be affected.
- If this authorization originated with the provider, I will receive a copy of this form after I sign it.

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

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

TO OBTAIN 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	TO SEND 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 SEND MEDICAL RECORDS TO NEMOURS PRIMARY CARE BY FAX: DE – (302) 298-8995 ORL/CHA – (321) 388-0111
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For Questions, please call 866-956-7299, press option #1