**Authorization to Use/Disclose Protected Health Information**

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Release Medical Records From:**  Facility name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Disclose Medical Records To:**  Facility name: Next Century Medical Care, LLC  Street address: 1400 Philadelphia Pike Suite A4  City/State/Zip: Wilmington, DE 19809  Phone #: (302) 375-6746  Fax #: (302) 375-6822 |

I am requesting medical records for dates: FROM: TO: ALL

**Information to Be Disclosed**

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| Check all that apply:  \_\_\_\_\_\_\_\_\_\_ Entire Inpatient Medical Record  \_\_\_\_\_\_\_\_\_\_ Entire Outpatient Medical Record  \_\_\_\_\_\_\_\_\_\_ Abstract of Medical Record  \_\_\_\_\_\_\_\_\_\_ Outpatient Office Note/Encounter  \_\_\_\_\_\_\_\_\_\_ Laboratory results  \_\_\_\_\_\_\_\_\_\_ Imaging reports (X-ray, MRI, CT, etc.)  \_\_\_\_\_\_\_\_\_\_ Imaging films  \_\_\_\_\_\_\_\_\_\_ Pathology Reports  \_\_\_\_\_\_\_\_\_\_ Operative Notes  \_\_\_\_\_\_\_\_\_\_ History/Physical Examination  \_\_\_\_\_\_\_\_\_\_ Billing Statement  \_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Your initials are required to release the following:  \_\_\_\_\_\_\_\_\_\_ Psychiatric/Psychology Notes  \_\_\_\_\_\_\_\_\_\_ Psychological Evaluation & Results  \_\_\_\_\_\_\_\_\_\_ Genetic Testing  \_\_\_\_\_\_\_\_\_\_ HIV Laboratory Results  \_\_\_\_\_\_\_\_\_\_ Drug/Alcohol Results  \_\_\_\_\_\_\_\_\_\_ STD Results  **Please note: Some of these items may require signature of the minor if age 13 and above.** |
| Purpose of Disclosure: (Check all that apply)  \_\_\_\_\_ Continuing care with another provider/facility  \_\_\_\_\_ Transfer of care  \_\_\_\_\_ Personal copy  \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I may revoke this authorization at any time by notifying the “Sent From” organization noted above in writing. I understand that my revocation does not affect any disclosure made prior to the revocation being received.

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_