**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, LLCStreet address: 1400 Philadelphia Pike Suite A4City/State/Zip: Wilmington, DE 19809Phone #: (302) 375-6746Fax #: (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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_