# AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

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

**Phone:** _____ **Address:** _____

| **RELEASE MEDICAL RECORDS FROM:** | **DISCLOSE MEDICAL RECORDS TO:** |
|---|---|
| Facility or Name: | Facility or Name: **Dr. Michael Bober / Angie Duker, A.I. duPont Hospital for Children, Division of Medical Genetics** |
| Address: | Address: **1600 Rockland Road, Wilmington, DE 19803** |
| City/ST/Zip: | City/ST/Zip: |
| Phone #: Fax: | Phone #: **302-651-5916** Fax: **302-651-5033** |

## 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.

## INFORMATION TO BE DISCLOSED *(please specify)*:

☐ Entire Inpatient Medical Record
☐ Entire Outpatient Medical Record

OR select specific reports below:

- ☐ Abstract of Medical Record
- ☐ Outpatient Clinic Note/Encounter
- ☐ All Diagnostic Test Results
- ☐ Labs
- ☐ Imaging Reports (x-rays, MRI, etc.)
- ☐ Pathology Reports
- ☐ Operative Notes
- ☐ History/Physical Exam
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Medications
- ☐ Billing Statement
- ☐ Other (specify below):

Your initials are required to release the following:

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

## 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: