



AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____
Phone: _____

Date of Birth: _____
Address: _____

MR#
(Staff to Complete):

RELEASE MEDICAL RECORDS FROM:

Facility or Name: _____

Address: _____

City/ST/Zip: _____

Phone #: _____ Fax: _____

DISCLOSE MEDICAL RECORDS TO:

Facility or Name: **Dr. Michael Bober / Angie Duker
A.I. duPont Hospital for Children
Division of Medical Genetics**

Address: **1600 Rockland Road
Wilmington, DE 19803**

City/ST/Zip: _____

Phone #: **302-651-5916** Fax: **302-651-5033**

I AM REQUESTING MEDICAL RECORDS FOR DATES:

FROM: _____ **To:** _____ **ALL**

INFORMATION TO BE DISCLOSED (please specify):

- Entire Inpatient Medical Record
- Entire Outpatient Medical Record

OR select specific reports below:

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

FEES: I understand and agree that there may be costs associated with this request in compliance with State and Federal Copying laws.

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: