Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth: _____/_____/_____
Address: _____City: _____ State: _____ Zip: _____
E-Mail Address: _____ Phone: _____Social Security #: **XXX – XX** - __ __ __ __

I request that my protected health information (PHI) from _____be disclosed to:
Recipient Name: _____
Address: _____ City: _____ State: _____ Zip: _____
E-Mail Address: _____Phone: _____
Fax (healthcare provider only): _____

I authorize the following PHI to be released from my medical record(s):

☐ Discharge Summary Date:_____ ☐ Consultation Reports Date: _____
☐ History and Physical Date:_____ ☐ Radiology Report Date: _____
☐ Operative Report Date:_____ ☐ Laboratory Report Date: _____
☐ Test Results Date: _____ Type:_____ ☐ EKG Report Date _____
☐ Emergency Room Record Date: _____
Detailed Description: _____
Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records ☐ Yes ☐ No Dates: _____
HIV Testing and Results ☐ Yes ☐ No Dates: _____
Mental Health or Psychotherapy Records ☐ Yes ☐ No Dates: _____
Covering the period of health care from: ☐ ***Specific Date(s):*** _____ ***to*** _____

Purpose for requesting information: ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care

Disclosure Format (Paper is default if not marked): ☐ US Mail – paper format, ☐ FAX (healthcare provider only), ☐ E-Mail – secure format **OR** ☐ CD – secure electronic format

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 424 Savannah Road Lewes, DE 19958. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

_____ ____/____/____ _____ _____ ____/____/____ _____
(Signature of Patient) (Date) (Time) (Signature of Witness) (Date) (Time)

If you are signing as a Personal Representative for the above patient*, you will be asked to provide proof of your identity and of your authority to sign for the patient. Please fill out and sign below:*

Your name (please print): _____ Your relationship to the patient: _____
Your signature: _____ Date: _____/_____/_____ Time: _____ am pm

FOR OFFICE USE ONLY:
Information released by: _____ Date: _____/_____/_____ Time: _____ am pm