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: