



* 200401 *

PATIENT INFORMATION: (please print)

Medical Record Number: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Name at Time of Treatment (if different than above): _____

Date of Birth: _____ Phone: _____ Email (optional): _____

Street Address: _____ City: _____ State: _____ Zip: _____

FACILITY OR INDIVIDUAL RELEASING MEDICAL RECORDS: <small>(PLEASE NOTE: RELEASING FACILITY WILL DEFAULT TO NEMOURS IF LEFT BLANK.)</small>				FACILITY OR INDIVIDUAL RECEIVING MEDICAL RECORDS:			

Please send medical records by:
First Choice: CD Fax Paper NemoursApp Email _____
Second Choice: CD Fax Paper NemoursApp Email _____

***If the requested information is not readily producible in the selected format, a readable hard copy will be sent by mail.**

INFORMATION TO BE RELEASED: (check all items to be released):

Covering the period(s) of care (list applicable dates): _____

Specify department(s), provider(s) optional: _____

_____ (Inpatient Abstract)
_____ (Outpatient Abstract)

Patient or Parent/Legal Representative Initials are REQUIRED to release the following:

Purpose of Disclosure (please specify as required by HIPAA regulations): _____

AUTHORIZATION:

Patient/Legal Representative Signature: _____ Date: _____ TIME: _____AM/PM

Patient/Legal Representative (Printed Name): _____ Relationship to Patient: _____

TO _____ COPIES OF MEDICAL RECORDS FROM NEMOURS: NOTICE: For Questions, please call 866-956-7299, press option #1	TO _____ MEDICAL RECORDS TO NEMOURS SPECIALTY CARE BY FAX:	TO _____ MEDICAL RECORDS TO NEMOURS PRIMARY CARE BY FAX:
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AUTHORIZATION TO RELEASE/OBTAIN PATIENT INFORMATION

Instructions for Form Completion:

Complete Patient Name, Name at Time of Treatment (if different), date of birth, phone, Email, and