Drexel Medicine

Authorization to Disclose Highly Confidential/ Request for Access to Medical Information

Patient Name and Date of Birth are required.

Patient Name:_____ **Date of Birth:** _____

Please check one of the two choices:
Check this if you are sending your records to your new doctor.
Check this if you are sending your records to yourself.

Please select (X) either an Authorization to Disclose Highly Confidential Information or the Request for Access to Medical Information. This authorizes Drexel University to disclose/Release information as described below.

☐ **Authorization to Disclose Highly Confidential Information**

☐ **Request for Access to Medical Information**

Please provide your full address and phone number.

Address:_____

_____ **Phone #:** _____

I hereby consent and authorize:

Please provide the name of the Drexel practice you would like your records from. This is required.

Name of Person or Organization: _____

Address:_____

Phone Number: _____ Fax Number: _____

To release and disclose medical information to:

Please provide the name and address of who and where you want your records to be sent to.
This is required.

Name of Person or Organization: _____

Address: _____

Phone Number: _____ Fax Number: _____

Please let us know why you want your records.

For the Purpose of: _____

Please give the dates of when you visited the Drexel Medicine practice.

For the following dates of service: _____

Please choose how you would like to receive your records. Choose “Fax” or “Copy/Mail” or “Telephone.”

Please release these records via ___Fax___Copy/Mail___Telephone. I understand that depending on the volume of materials and/or potential confidentiality issues, it may not be possible for records to be faxed. In these cases, the records will be copied and mailed.

Please tell us what information to share.
You must choose “include” or “do not include” for each of the four lines. These are required.

__Please Include__Do Not Include **Any and all psychological and psychiatric information (separate authorization is required for psychotherapy notes)**
__Please Include__ Do Not Include **Any and all drug and alcohol treatment information**
__Please Include__Do Not Include **Any and all HIV/AIDS related treatment information**
__Please Include__Do Not Include **Any and all genetic information**

Patient Name and Date of Birth are required.

Please note: This request expires on date below, a period of time not to go over one (1) year.

Print the name of the patient. This is required.

Patient signs and dates form. This is required.

If you are NOT the patient, but represent the patient, please fill in these two (2) lines.

Drexel Medicine

Authorization to Disclose Highly Confidential/ Request for Access to Medical Information

Patient Name:_____ **Date of Birth:** _____

I have been informed and understand that this authorization, except for action already taken, may be voided by me at any time. I am further aware that, unless ended, this authorization to release information will expire on the date indicated below, a period of time not to exceed one year.

If this authorization was obtained as a condition of obtaining insurance coverage other laws provide the insurer with the right to contest a claim under the policy or the policy itself.

This office generally may not condition services upon my signing an authorization, unless the services are research-related or for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy rule.

This authorization is effective from____/____/____ to ____/____/____
and has been fully explained to me, and my signature certifies that I understand its contents.

_____
Printed name of Patient

_____ _____
Signature of Patient Date

_____
Printed name of Parent/Authorized Representative

_____ _____
Signature of Parent/Authorized Representative Date

_____
Printed name of Practice Representative

_____ _____
Signature of Practice Representative Date

The form is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, as explained in the Notice of Privacy Practices presented at patient registration by the physician's office staff. The form also complies with applicable Federal and applicable State Law.