



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

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

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

**I hereby consent and authorize Drexel University to release and disclose medical information:**

**From the following Drexel clinic (practice), provider or department:**

Name of Clinic, Provider or Department: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number (optional): \_\_\_\_\_

**To the following Organization/Provider (s)/Person (s):**

Name of the Organization/Provider/Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**For the dates of service/treatment:** From: \_\_\_\_\_ To: \_\_\_\_\_

All dates of service/treatment

**For the purpose of:**  Personal  Legal  Insurance  Continuation of Care  
 Other \_\_\_\_\_

\_\_\_ 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 Substance Use Disorder 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**



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

**Delivery Method:**

Please select your preferred delivery method:

- Fax/Fax Number \_\_\_\_\_
- Email/Email address: \_\_\_\_\_
- Mail/Mailing address: \_\_\_\_\_

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

Drexel University will make reasonable efforts to comply with this request within thirty (30) days for information maintained or accessible on site or within sixty (60) days for information that is not maintained on site. If Drexel Health is unable to comply with this request within the specified time periods, it may extend the applicable deadline to thirty (30) days by notifying you in writing.

This authorization is effective from \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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