



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

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

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

Phone #: \_\_\_\_\_

I hereby consent and authorize:

Name of Person or Organization: \_\_\_\_\_

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

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

To release and disclose medical information to:

Name of Person or Organization: \_\_\_\_\_

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

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

For the Purpose of: \_\_\_\_\_

For the following dates of service: \_\_\_\_\_

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 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**



## 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.