Nemours

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

(PLEASE SEE REVERSE SIDE FOR FORM COMPLETION INSTRUCTIONS)

Patient Name: _____ **Date of Birth:** _____ **MR#** *(Staff to Complete):* _____

Phone: _____ **Address:** _____

I would like to receive these records via ☐ Email ☒ Fax ☒ CD ☒ Paper

RELEASE MEDICAL RECORDS FROM:

Facility or Name: Nemours

Department: _____

Point of Contact: Medical Records

Address: 807 Children's Way

City/State/Zip: Jacksonville, FL 32207

Phone #: 904-697-3600 Fax: 904-697-3927

DISCLOSE MEDICAL RECORDS TO:

Facility or Name: The Webster School

Department: Nursing

Point of Contact: Nina Hall, RN

Address or Email Address: 420 N. Oragne St.

City/State/Zip: St. Augustine, FL 32084

Phone #: 904-547-3802 Fax: 904-547-3865

I AM REQUESTING MEDICAL RECORDS FOR DATES: FROM: _____ TO: _____

- ☒ Abstract of Medical Record
- ☐ Outpatient Clinic Note/Encounter
- ☐ Labs/Pathology Reports
- ☐ Pathology Slides/Blocks
- ☐ Imaging Reports (x-rays, MRI, etc.)
- ☐ Imaging Films
- ☐ Echocardiogram Tapes
- ☐ Electrocardiogram
- ☐ Verbal Communication with Health Professional
- ☐ Operative Notes
- ☐ History/Physical Exam
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Medications
- ☐ Photos
- ☐ Billing Statements
- ☐ Appointments/Scheduling
- ☐ Other (specify below): _____

Your initials are required to release the following:

- _____ Psychiatric/Psychology Notes
- _____ Psychological Evaluations & Results
- _____ Genetics Testing
- _____ HIV Reports/STD Reports
- _____ Drug/Alcohol Results
- _____ Adolescent Encounter

Please Note: If requesting an Adolescent Encounter, the signature of the minor is required_____

PURPOSE OF DISCLOSURE *(please specify)*:

☐ Continuing care with another physician or hospital

☐ Transfer of Care ☐ Personal Copy ☒ Other: Plan of care at school

EXPIRATION DATE OR EVENT:

(if left blank, this Authorization expires 90 days from the date signed)

Specify a date or event:_____

AUTHORIZATION:

1. I may revoke this authorization at any time by notifying the "Sent FROM" organization noted above in writing.
2. I understand that my revocation does not affect any disclosures made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy regulations.
4. I have the right to inspect or copy the information to be used/disclosed as permitted by federal law.
5. I may refuse to sign this authorization and that it is strictly voluntary.
6. If I do not sign this form, my health care and the payment for my health care will not be affected.
7. If this authorization originated with the provider, I will receive a copy of this form after I sign it.

FEES: I understand and agree that there may be costs associated with this request in compliance with State and Federal Copying laws. _____ *(please initial)*

Patient/Legal Representative Signature: _____ Date: _____

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

Instructions for Form Completion:

- ☐ Complete Patient Name, Date of Birth, Phone, and Address. The MR# section will be completed by the HIM Staff.
- ☐ Choose how you would like to receive your records by checking one of the boxes. If no box has been selected – we will mail your records to you.
- ☐ Release Medical Records From box: List the facility from where records are to be released.
- ☐ Disclose Medical Records To box: List the person/facility that should receive the records.
- ☐ I am requesting Medical Records for Dates section: Identify the specific date range for which you are requesting records.
- ☐ Within the box below identify specific reports that you are requesting.
- ☐ For an Abstract of the Medical Record:
  - o Inpatient abstract includes: History and Physical, Consults, Operative Report, Diagnostic Studies, Discharge Summary, Emergency Room Report
  - o Outpatient Abstract includes: All progress notes for each clinical division, Key Diagnostic Studies, Emergency Room Report, Operative Reports, Discharge Summary
- ☐ Your initials are required to release the following – You will only receive copies of these types of reports if initials are present. If requesting an adolescent encounter, the signature of the minor is required.
- ☐ Purpose of Disclosure – Please specify why you are requesting records.
- ☐ Expiration Date or Event – Please specify a date or event that you would like this Authorization to expire. If left blank, this Authorization will expire in 90 days.
- ☐ Please review the Authorization section, sign and print your name, enter the date, and your relationship to the patient (if the patient is 18 years or older – they must sign the Authorization).
- ☐ Note: Fees are calculated per page.
  Records requested for Continuing Care purposes can be sent directly to the Provider at no charge.

Fax your completed form to:

Delaware Valley: (302) 651-4480	Pensacola, FL: (850) 505-4710
Jacksonville, FL: (904) 697-3692	Nemours Children's Hospital, FL: (407) 650-7399

Email your completed form (for any location) to: patientrecords@nemours.org

You may sign up for My Nemours, a secure, confidential and easy-to-use website that gives patients and families 24-hour access to selected parts of their medical records. This free program is designed to help patients and families easily manage and receive important health information. To get started or for more information on MyNemours, please visit us at www.Nemours.org/mynemours, or call 877-696-3668, Monday through Friday from 8:00 a.m. to 5:00 p.m EST.

Key:
MRI: Magnetic Resonance Imaging
HIV: Human Immunodeficiency Virus
STD: Sexually Transmitted Disease