NEMOURS CHILDREN'S HEALTH

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AUTHORIZATION FOR NEMOURS TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

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 RELEASING MEDICAL RECORDS:				**FACILITY RECEIVING MEDICAL RECORDS:**			
Facility or Name:				Facility or Name:	Hope Vision Development Center		
Address:				Address:	235 Citrus Tower Blvd., #107		
City/ST/Zip:				City/ST/Zip:	Clermont, FL 34711		
Phone #:		Fax:		Phone #:	352-243-4673	Fax:	352-260-0884

Please send medical records by: ☐ **CD** ☒ **Fax** ☐ **Paper** ☐ **NemoursApp** ☐ **Email** _____

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:* _____

☐ History and Physical, Consults, Operative Report, Diagnostic Studies, Discharge Summary, Emergency Room Report **(Inpatient Abstract)**
☐ All office visits for each clinical division, Key Diagnostic Studies, Emergency Room Report, Operative Reports **(Outpatient Abstract)**
☐ Discharge Summary ☐ Outpatient Office Visit ☐ Operative Report ☐ Imaging Report ☐ Imaging Films ☐ Lab Reports
☐ Cardiology Images ☐ Accounting of Disclosure ☐ Path Slides/Blocks ☐ Other (please specify): _____

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

_____ Psychiatric/Psychology Social Work Notes _____ Psychological Evaluation & Results
_____ Genetics Testing _____ HIV Reports/STD Reports _____ Drug/Alcohol Results

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

☐ Continuing Care with another physician/hospital ☐ Transfer of Care ☐ Other _____

AUTHORIZATION:

1. I may revoke this authorization at any time by notifying the originating 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. Authorization will expire 90 days after signature unless indicated otherwise (insert date): _____
7. If I do not sign this form, my healthcare and the payment for my healthcare will not be affected.
8. If this authorization originated with the provider, I will receive a copy of this form after I sign it.

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

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

TO *OBTAIN* COPIES OF MEDICAL RECORDS FROM NEMOURS:	**TO *SEND* MEDICAL RECORDS TO NEMOURS SPECIALTY CARE BY FAX:**	**TO *SEND* MEDICAL RECORDS TO NEMOURS PRIMARY CARE BY FAX:**
Fax: 302-651-4480 Email: patientrecords@nemours.org **NOTICE:** There may be costs associated with this request. For personal copy, CD/Fax/Email/Paper: $6.50	ORL – (407) 650-7124 PNS – (850) 473-4543 DE – (302) 295-0718 JAX - (904) 697-3927	DE - (302) 298-8995 ORL/CHA – (321)388-0111

For Questions, please call 866-956-7299, press option #1

NEMOURS CHILDREN'S HEALTH

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 address. The Medical Record # section will be completed by the HIM Staff.
- RELEASING/RECEIVING Medical Records: List the facility/person you wish to Release records in the box on the left and list facility/person you wish or Receive medical records in the box on the right.
- **Information to be released**:
    - Please list the dates of service if applicable
    - Please list the department/s or provider/s if applicable
    - Please identify the specific reports that you are requesting
    - Your initials are required to release the following: You will only receive copies of these type of reports if initials are present.
- Purpose of disclosure – Please specify why you are requesting records
- Signatures – please review the Authorization section, sign and print your name, enter the date and your relationship to the patient (if the patient is 18 or older – they must sign the Authorization).
    - NOTE: Authorization will expire in 90 days after signature unless otherwise specified *(see #6 under authorization)*.

For questions, please call: 866-956-7299, press option #1

Nemours App

You can sign up for the Nemours app, a secure, confidential, and easy-to-use app/web site that gives patient families 24-hour access to selected parts of their medical records. This **free** program is designed to help patient families easily manage and receive important health information. Get easy access to your child's medical records, see a pediatrician on demand, and check our award-winning educational content to help keep your child healthy.

To get started, download the Nemours app from the Apple App Store or Google Play Store, or visit our website at https://app.nemours.org, and click the Sign Up link.

Key: HIV: Human Immunodeficiency Virus; STD: Sexually Transmitted Disease