



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:** _____

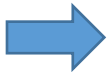
<p>TO OBTAIN COPIES OF MEDICAL RECORDS FROM NEMOURS: Fax: 302-651-4480 Email: patientrecords@nemours.org NOTICE: There may be costs associated with this request. For personal copy, CD/Fax/Email/Paper: \$6.50</p>	<p>TO SEND MEDICAL RECORDS TO NEMOURS SPECIALTY CARE BY FAX: ORL – (407) 650-7124 PNS – (850) 473-4543 DE – (302) 295-0718 JAX - (904) 697-3927</p>	<p>TO SEND MEDICAL RECORDS TO NEMOURS PRIMARY CARE BY FAX: DE - (302) 298-8995 ORL/CHA – (321)388-0111</p>
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For Questions, please call 866-956-7299, press option #1

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