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.