

Records Release—HIPAA Compliant

Patient Name: _____

Date of Birth: _____ Social Security No: _____

I authorize the use and disclosure of the above-named individual's health information described below. *Please check one.*

Mill Creek Medical Associates is authorized to release the above-named individual's health information to the following individual(s). **A copy fee may be charged. Please see attached policy.**

The following individual(s) or organization(s) are authorized to make the disclosure **to Mill Creek Medical Associates**

Name: _____ Address: _____

Name: _____ Address: _____

The type of information to be used or disclosed (requested) is as follows:

- | | |
|--|---|
| <input type="radio"/> Problem list | <input type="radio"/> Entire record |
| <input type="radio"/> Medication list | <input type="radio"/> X-Ray & imaging report (specify dates): _____ |
| <input type="radio"/> List of allergies | <input type="radio"/> Consultation report (specify consulting physician's name & date): _____ |
| <input type="radio"/> Immunization records | <input type="radio"/> Operative report (specify procedure & date): _____ |
| <input type="radio"/> Most recent history/diagnosis | <input type="radio"/> Discharge summary for admission on: _____ |
| <input type="radio"/> Discharge summary for admission on: _____ | <input type="radio"/> Progress notes (range of dates): _____ |
| <input type="radio"/> Lab results (list specific tests & dates): _____ | <input type="radio"/> Other (please specify) : _____ |
| <input type="radio"/> Psychotherapy notes | |

State and Federal law protect the following information. If any of this information applies to you, please indicate any or all information you would like released.

- Alcohol or drug abuse treatment records Psychiatric treatment HIV treatment

The information for which I am requesting disclosure will be used for the following purpose:

- | | |
|---|---|
| <input type="checkbox"/> My personal use | <input type="checkbox"/> To evaluate my eligibility for life insurance coverage |
| <input type="checkbox"/> Insurance (psychiatry) | <input type="checkbox"/> To evaluate my eligibility for disability benefits |
| <input type="checkbox"/> New Physician | <input type="checkbox"/> At the request of my attorney: Name _____ |
| <input type="checkbox"/> Other (please describe): _____ | |

I understand that I have the following rights:

- **Right not to sign.** You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by Mill Creek Medical Associates, except when health services are solely for the purpose of reporting to a third party. An example is a pre-employment physical.
- **Right to revoke.** You may revoke this authorization at any time. Your revocation will not apply to any release we have already made in response to this authorization. To revoke this authorization, you must submit a written revocation to our privacy office at the following address:
Mill Creek Medical Associates, Attention: Privacy Officer, 4512 Kirkwood Highway, Suite 301, Wilmington, DE 19808

Re-disclosure. I understand that once the information listed above has been disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.

Expiration date or event _____

I have read and understand this authorization, and authorize the use and/or disclosure of the health information as described in this authorization.

Signature of patient (or personal representative)

Date

Name of personal representative

Relationship to patient