Mill Creek Medical Associates
4512 Kirkwood Highway, Suite 301, Wilmington, DE 19808
302-999-0137 PHONE * 302-999-1042 FAX

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:

- o Problem list
- o Medication list
- o List of allergies
- o Immunization records
- o Most recent history/diagnosis
- o Discharge summary for admission on: _____________
- o Lab results (list specific tests & dates): _____________ ____
- o Psychotherapy notes
- o Entire record
- o X-Ray & imaging report (specify dates): ____________
- o Consultation report (specify consulting physician's name & date): _________________________________
- o Operative report (specify procedure & date):_________ ____
- o Progress notes (range of dates): ___________________ ____
- o Other (please specify) : _________________________

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:

☐ My personal use
☐ Insurance (psychiatry)
☐ New Physician
☐ To evaluate my eligibility for life insurance coverage
☐ To evaluate my eligibility for disability benefits
☐ At the request of my attorney: Name______________________________
☐ 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