200 Banning Street, Suite 110
Dover, DE 19904
302-346-4000 Main Line 302-741-2279 Fax

Authorization to Release Medical Records

Please note that request for release of medical records can take up to 72 hour

Complete the following for the individual whose information is being requested:

Name: ____ Birth Date: ___________

Street Address: ___________________________________ City / State/Zip: ________________________________

Purpose of Request:

☐ Personal ☐ Legal Review ☐ Insurance Review ☐ Medical Care ☐ Other (please describe): _________________

I am requesting the following Protected Health Information: Date of Service: ___________ Provider: ______________

☐ Registration Form	☐ Laboratory Reports	☐ Progress Notes	☐ Entire Chart
☐ History and Physical	☐ X-ray Reports	☐ Physicians Orders	☐ Detail Billing
☐ X-ray Films	☐ Nurses' Notes	☐ Pathology	☐ Operative Report

☐ Other: ____

Please mail the requested Protected Health Information to:

☐ I will pick up once completed please contact me at: ____

☐ Electronically send to the following email: ____

This authorization shall terminate upon the earliest of the following to occur: (i) the termination of my association with either the Center or the Recipient; (ii) the termination of the affiliation between the Center and the Recipient; or (iii) my revocation of this authorization.

I understand that I may refuse to sign this authorization. I understand that that the Center will not condition the commencement or the continuation of treatment on my decision as to whether to provide this authorization, nor would my refusal to sign this authorization affect any payment, enrollment or eligibility for benefits from any source. I further understand that I may revoke this authorization at any time by providing written notice of my intent to revoke this authorization to the Center at: Delaware Surgery Center, LLC. Attn: Privacy Officer, 200 Banning Street, Suite 110, Dover, DE 19904.

I understand this authorization cannot be revoked to the extent that action has already been taken in reliance on this authorization prior to the date the Center received my written request to revoke authorization.

The Center will not use or disclose personal health information beyond the scope of this authorization without my written consent or authorization. I understand that disclosed information may be subject to re-disclosure by the recipient, and may no longer be considered to be protected health information pursuant to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

Patient Signature: ___________________________________ Date: ______________ ID of Requestor: ______________

Legal Guardian Signature: _____________________________ Date: ______________ID of Requestor: ______________

Witness Signature: ___________________________________ Date: ______________

** NOTE: If you are the Personal Representative, other than a parent or legal guardian, please attach a copy of any document verifying your position as Personal Representative.