AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I hereby authorize the release of my health information as listed below.

Patient name:_____ **Date of Birth:**_____
Address _____
Telephone: _____

Person or entity authorized to release information:

☐ _____

☐ Any physician, physician office, hospital, clinic, health plan or health insurer or any other person or entity that has any health or medical information about me.

Person or entity authorized to receive information: _____
Address _____

☐ The Court and other entities or individuals as permitted by the Court
☐ The Office of the Child Advocate/Court Appointed Guardian ad litem/Court Appointed Special Advocate
☐ Delaware Deputy Attorney General: _____

Description of information:

☐ My entire health record
☐ Information in connection with my examination/evaluation
☐ Health information related to services provided on (date(s)) _____
☐ Other: Description of information: _____

Special Records: Medical Records to be released **will not include** records of drug and alcohol abuse program treatment, mental health treatment or STD, HIV, or genetic information records unless the specific boxes below are checked. This information is protected by special laws. Checking the boxes is not a representation that such information exists.

☐ Include drug and alcohol records ☐ Include HIV records ☐ Include STD records
☐ Include genetic information records ☐ Include mental health records

Purpose of Release of Information:

☐ Personal Use ☐ Medical Treatment/Management ☐ Legal Proceedings
☐ Employment Related purposes ☐ Insurance Related ☐ Other _____

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1. This authorization will expire: ☐ Date:_____ ☐ Event:_____ ☐ One year
   Unless otherwise specified, this authorization will expire 90 days after the date of this request.
2. I understand that I may revoke this authorization at any time by notifying any provider or health plan to whom I have provided this authorization that I wish to revoke the authorization. I understand that revocation will not have any affect on actions taken before the revocation was received.
3. This authorization is voluntary. I understand that my treatment or payment for services will not be affected if I do not sign this authorization.
4. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, the information may no longer be protected by federal privacy regulations.

_____ _____
Signature of patient or patient's representative **Date**

Printed name of patient's representative:_____

Relationship to the patient:_____

To Recipient: *Information regarding drug and/or alcohol use, abuse, treatment or referrals for treatment has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 A general authorization for the release of medical or other information is NOT sufficient for this purpose The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*