Nanticoke Memorial Hospital
801 Middleford Road; Seaford DE 19973
Phone (302) 629-6611

NANTICOKE
MEMORIAL HOSPITAL

AUTHORIZATION TO RELEASE & DISCLOSE HEALTH INFORMATION from NANTICOKE

Patient Name:	**Email Address:**	**DOB:**	**MRN#**

Address:				
City:	**State:**	**Zip:**	**Phone:** ( )	**Cell:** ( )

Persons authorized to make health care decisions on an individual's behalf, and make requests to release such information, include an adult patient; or a legally authorized representative: legal guardian of a minor; relative caregiver; emancipated minor; married minors; minor parent on the behalf of his/her child; minors enlisted in the service; certain minors if the minor is allowed by State law to consent to the procedure or treatment; certain custodial organizations. The name/identification of the patient or authorized representative is ☐ Patient listed above or ☐ Authorized Representative (complete information below):

Authorized Representative (if not patient)	Authorized Representative **(Only required if patient is not authorized to make health care decisions):**	Relationship to patient:		
	Address:(use "SAME" as above if applicable)	City:	State:	Zip:

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act Standards for Privacy of Individually Identifiable Health Information (Privacy Rules) [Specifically 45 CFR §164.508].

I request and authorize Nanticoke Memorial Hospital to release or disclose patient health information to:

Person, Company or Provider Name:	**Phone:** ( )	**Fax:** ( )
Address:	**City:**	**State:** **Zip:**

For the purpose of: _____

The information to be used/disclosed is described as follows:

☐ Specific Information for Date of Service(s) _____(e.g. x-ray or lab) _____

☐ Entire Record for Date of Service(s) _____(including but not limited to most recent History and Physical, Problem Lists, Medication Lists, Immunization Records, Growth Charts, and any pertinent office notes, x-ray reports, lab results, hospital discharge summaries, consultant reports, etc.)

☐ Psychotherapy Notes for Date of Service (s) _____

I give special permission to release any information regarding: **[*Initial on applicable line(s) below*]:**

_____**Psychiatric/Mental Health** (other than Psychotherapy Notes) _____**Alcohol/Substance Abuse**

_____**HIV/Sexually Transmitted Disease** _____**Pregnancy of minor** _____**Sexual Assault/Sexual Abuse**

(Note: certain minors may have the right to release this information without further consent of parent or guardian.)

Under the Privacy Rules, I have the right to revoke this authorization at any time, and Nanticoke Memorial Hospital must cease using this authorization. However, Nanticoke Memorial Hospital may complete any actions it initiated prior to my revocation and which rely on my medical information for completion. If I choose to revoke this authorization then I understand I must provide the revocation in writing and send to Nanticoke Memorial Hospital, 801 Middleford Road; Seaford, DE 19973; Attn: Release of Information, Medical Records.

I understand that I may refuse to sign this Authorization, and Nanticoke Memorial Hospital may not condition treatment on whether or not you sign. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Privacy Rules.

This authorization will automatically expire twelve (12) months from the date signed. I understand that I may revoke this consent in person or in writing at any time, except to the extent that action has been taken in reliance thereon.

Signature of Patient or Authorized Representative **Relationship** ☐ Patient ☐ Other – describe: **Date:**

_____ _____

Signature of Witness _____ **Date:**

☐ **This authorization was received by phone by** _____ **Date:**
Employee Name