Delaware Center for Maternal Fetal Medicine of Christiana Care, Inc.

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Authorization for Release of Medical Records

Patient's Name:____ Date of Birth:_________________________

Address: ____

City/State/Zip Code: ______________________________________ Phone: ______________________________

Date of Request: ____ Date Needed: ________________________

Authorization is valid for this request only.

____ **I authorize DCMFMCC to release information to**	____ **I authorize DCMFMCC to obtain information from:**
____ Name of Provider or Self	____ Name of Provider or Facility
____ Address	Address
____ City, State, Zip Code	City, State, Zip Code
____ **Phone** including area code **Fax**	Phone including area code Fax

Types of Records Requested: (Check one)

________ All records- no limitations. Records to be released may contain information pertaining to HIV/AIDS. drug and alcohol, psychiatric, and/or metal diagnosis/treatment

________ Specific information____

Purpose of medical record release:	**Records released for personal use:**
_________ **Transfer of care**	_________ Mailed Certified Receipt to the address indicated above.
Information for additional providers	_________ I will pick up- ID required and payment required.

I hereby authorize DCMFMCC to release of all my medical information unless limited above to the agency/institution/physician identified. DCMFMCC is not responsible as the released information may no longer be protected by federal Privacy Rules and may be re-disclosed by the recipient.

____

Signature of Patient or Representative **Date**

____

Relationship to Patient (if requester is not the patient)

Requested by: ______________________________	***Reviewed by:*** ___________________________________
Date Request Sent: _________________________	***Date Records Sent:*** ___________________________
Date Records Received: _____________________	***Processed by:*** _________________________________