



Authorization to Disclose Highly Confidential/ Request for Access to Medical Information

Patient Name: _____ Date of Birth: _____
Address: _____
Phone Number: _____

Please select (X) either an Authorization to Disclose Highly Confidential Information or the Request for Access to Medical Information. This authorizes Drexel University to disclose/release information as described below.

- Authorization to Disclose Highly Confidential Information
- Request for Access to Medical Information

I hereby consent and authorize Drexel University to release and disclose medical information:

From the following Drexel clinic (practice), provider or department:

Name of Clinic, Provider or Department: _____

Address: _____

Phone Number: _____ Fax Number (optional): _____

To the following Organization/Provider (s)/Person (s):

Name of the Organization/Provider/Person: _____

Address: _____

Phone Number: _____ Fax Number: _____

For the dates of service/treatment: From: _____ To: _____

All dates of service/treatment

For the purpose of: Personal Legal Insurance Continuation of Care
 Other _____

___ Please Include ___ Do Not Include **Any and all psychological and psychiatric information (separate authorization is required for psychotherapy notes)**

___ Please Include ___ Do Not Include **Any and all drug and alcohol treatment information**

___ Please Include ___ Do Not Include **Any and all Substance Use Disorder treatment information**

___ Please Include ___ Do Not Include **Any and all HIV/AIDS related treatment information**

___ Please Include ___ Do Not Include **Any and all genetic information**



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Patient Name: _____ Date of Birth: _____

Delivery Method:

Please select your preferred delivery method:

- Fax/Fax Number _____
- Email/Email address: _____
- Mail/Mailing address: _____

I understand that depending on the volume of materials and/or potential confidentiality issues, it may not be possible for records to be faxed and/or emailed. In these cases, the records will be mailed. I have been informed and understand that this authorization, except for action already taken, may be voided by me at any time. I am further aware that, unless ended, this authorization to release information will expire on the date indicated below, a period not to exceed one year.

If this authorization was obtained as a condition of obtaining insurance coverage other laws provide the insurer with the right to contest a claim under the policy or the policy itself. This office generally may not condition services upon my signing an authorization, unless the services are research-related or for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy rule.

Drexel University will make reasonable efforts to comply with this request within thirty (30) days for information maintained or accessible on site or within sixty (60) days for information that is not maintained on site. If Drexel Health is unable to comply with this request within the specified time periods, it may extend the applicable deadline to thirty (30) days by notifying you in writing.

This authorization is effective from ____/____/____ to ____/____/____

My signature certifies that I understand its contents.

Printed Name of Patient

Signature of Patient

Date

Printed Name of Parent/Authorized Representative

Signature of Parent/Authorized Representative

Date