CNMRI, PA - Locations
1095 S. Bradford Street, Dover DE 19904 (302) 678-8100
111 Neurology Way, Milford DE 19963 (302) 422-0800

Central Mailing Address: 1095 S. Bradford Street, Dover DE 19904 (302) 678-8100

Patient Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME
DATE OF BIRTH: _____-_____-_____ SS#: _____-_____-_____ MEDICAL RECORD #: _____
MO DAY YR
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

TYPE OF RELEASE: (circle one) CNMRI RECORDS OUTSIDE FACILITY RECORDS

I hereby authorize _____ (Print Name of Provider) to release information from my medical record as indicated below:

- **Requests to OUTSIDE FACILITIES please complete the provider's address for which records are requested.**
- **Requests for CNMRI RECORDS, please complete provider's name and address of where you want your records mailed.**

PROVIDER NAME:_____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

If outside facility record request: CNMRI Physician Requesting Information:_____
INFORMATION TO BE RELEASED:

	DATES(if applicable):
❑ History and physical exam	_____
❑ Progress notes	_____
❑ Lab reports	_____
❑ X-ray reports	_____
❑ Other: _____	_____
_____	_____

I specifically authorize the release of information relating to:
- ❑ Substance abuse (including alcohol/drug abuse)
- ❑ Mental health (including psychotherapy notes)
- ❑ HIV related information (AIDS related testing)

X_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: ❑ Changing physicians ❑ Consultation/second opinion ❑ Continuing care ❑ Legal
❑ School ❑ Insurance ❑ Workers Compensation ❑ Other (please specify): _____

1. I understand that this authorization will expire 90 days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information:
   a.By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b.I understand I may see and copy the information described on this form if I ask for it.
5. I understand that in compliance with CNMRI policy and Delaware State Law, I will pay fees according to the number of pages being processed. These fees will be determined as follows: $2.00 per page for pages 1-10, $1.00 per page for pages 11-20, $0.90 per page for pages 21-60, $0.50 per page for pages 61 and above. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY (REQUEST FOR CNMRI RECORDS)
DATE REQUEST FILLED: _____ BY: _____