Nanticoke Memorial Hospital recognizes a patient's right under HIPAA to access copies of his/her health information.

Nanticoke Memorial Hospital
801 Middleford Road; Seaford DE 19973
Phone: (302) 629-6611 Fax: (302) 629-8373

FIN	MRN

NANTICOKE MEMORIAL HOSPITAL

Patient Request for NMH to Release Health Information

Patient Information (Please Print)			
Patient Name:		**Email Address:**	**DOB:**
Address:			
City: **State:** **Zip:**		**Phone:** ( )	**Cell:** ( )

What records do you want? (Check appropriate boxes below):

(There may be charges associated with producing requested records.)

Office ☐ Notes: ☐ Immunization Records ☐ Medication Lists ☐ Rehabilitation/Therapy Notes ☐ Other: _____

Primary Care: ☐ Bridgeville ☐ Delmar ☐ Federalsburg ☐ Georgetown ☐ Internal Medicine-Seaford ☐ Laurel ☐ Seaford

Specialty Care: ☐ Bariatric & Gen'l Surgery ☐ Diabetes & Endocrinology ☐ Gastroenterology ☐ General Surgery ☐ Nephrology ☐ Neurology ☐ Orthopedic ☐ Pulmonary ☐ Urology ☐ Women's Health

Immediate Care: ☐ Delmar ☐ Georgetown ☐ Laurel ☐ Seaford

Hospital ☐ Consultation Reports ☐ Discharge Summary ☐ Emergency Records ☐ History & Physical ☐ Operative Reports

☐ Entire Record Set (also includes Medication Lists, Nursing Notes, Physician Notes, Physician Orders, Problem Lists, etc)

Testing ☐ Cardiology/Echo/EKG ☐ Lab/Pathology Results ☐ Diagnostic/Radiology Reports

Images ☐ CT _____ ☐ Mammo _____ ☐ MRI _____ ☐ NM _____ ☐ US _____ ☐ Xray _____

Other _____

Note: Sensitive information including Psychiatric/Mental Health, Substance Abuse, HIV or Sexually Transmitted Disease, Pregnancy of a Minor, or Sexual Abuse may be included in the documentation requested.

For Dates of Service beginning: _____/_____/_____ through _____/_____/_____

How would you like your records delivered?

Record Format: ☐ Paper ☐ Electronic DVD ☐ Fax _____ ☐ Other: _____

Deliver by: ☐ US Mail ☐ In person ☐ Email/Web Link above ☐ Radiology Dept (fax ROI request to 302-628-6369)

WARNING: Nanticoke Memorial Hospital does not recommend delivery of Personal Health Information through unsecure email or web links.

Where do you want the information sent? (Fill in boxes below):

☐ Patient/Self; to address above OR ☐ Authorized Representative / Entity (indicated below):

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:
Phone:	Fax:		

Authorization by Patient or Authorized Representative:

Persons authorized to make health care decisions on an individual's behalf, and 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 below is:

Signature of ☐ **Patient OR** ☐ **Authorized Representative** _____ ☐ Minor has no ID – identify verified on back	**Signature of Parent or Legal Guardian of Minor 12-18 yrs** _____	**Date:**
Signature of Witness: _____ Ext _____ **Location**: _____		**Date:**
☐ **This authorization was received by phone by:** _____ **(Employee Name) Ext** _____		**Date:**

This authorization will automatically expire twelve (12) months from the date signed and a photocopy of this authorization will be granted the same authority as the original.

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