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

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MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

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 I		: (302) 629-6611 Fax: (302) 629-8373			MEMORIAL HOSPITAL
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 Pederalsburg Georgetown Internal Medicine-Seaford Laurel Seaford Specialty Care: Bridgeville Delmar Georgetown Internal Medicine-Seaford Laurel Seaford Specialty Care: Bridgeville Delmar Georgetown Georgetown Urology Momen's Health Immediate Care: Delmar Georgetown Laurel Seaford Hospital Consultation Reports Discharge Summary Emergency Records History & Physician Operative Rep 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 I Where do you want the information sent? (Fill in boxes below): Patient/Self; to address above OR Authorized Representative / Entity (indicated below): Address: (use "SAME" as above if applicable) City: State: Zip:					
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		(use "SAME" as above if applicable) City:			
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; min 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:	Address: (
Signature of Patient OR Authorized Representative Signature of Parent or Legal Guardian of Minor 12-18 yrs Date:	Address: (Phone: Author Persons authorized enlisted in	Fax: rization by Patient or Authorized Representative: thorized to make health care decisions on an individual's behalf, and req- representative: legal guardian of a minor; relative caregiver; emancipate the service; certain minors if the minor is allowed by State law to consen	uests to release such inford minor; married minors;	minor parent on	the behalf of his/her child; minors
Minor has no ID – identify verified on back	Address: (Phone: Author Persons authorized enlisted in name/ident Signature (Fax: rization by Patient or Authorized Representative: thorized to make health care decisions on an individual's behalf, and requestere representative: legal guardian of a minor; relative caregiver; emancipate the service; certain minors if the minor is allowed by State law to consentification of the patient or authorized representative below is: of Patient OR Authorized Representative Signat	uests to release such infor d minor; married minors; nt to the procedure or treat	minor parent on ment; certain cus	the behalf of his/her child; minors stodial organizations. The
Signature of Witness: Ext Location: Date:	Address: (Phone: Author Persons authorized enlisted in name/ident Signature (Fax: rization by Patient or Authorized Representative: thorized to make health care decisions on an individual's behalf, and requestere representative: legal guardian of a minor; relative caregiver; emancipate the service; certain minors if the minor is allowed by State law to consentification of the patient or authorized representative below is: of Patient OR Authorized Representative Signat	uests to release such infor d minor; married minors; nt to the procedure or treat	minor parent on ment; certain cus	the behalf of his/her child; minors stodial organizations. The

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.

(Employee Name) Ext

☐ This authorization was received by phone by: _