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

1 Centurian Drive, Suite 312
Newark, DE 19713
Phone:302-319-5680 Fax: 302-319-5681
www.dcmfm.com

Authorization for Release of Medical Information

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 Facility	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)

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

________ Specific information____

Records released for personal use (not to another medical provider):

________ Mailed Certified Receipt to the address indicated above. Fees may apply.

________ I will pick up- ID required and payment required.

________ Fax ______________________ DCMFMCC Employee verified secure receiving fax.
(print name)

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:*** ______________________