MEDICAL RECORD

Authorization for the Release of Medical Information

National Institutes of Health, Clinical Center
Health Information Management Dept.
10 Center Drive, MSC 1192
Building 10, Room B1L400
Bethesda, MD 20892-1192

Phone: (888) 790-2133 or (301) 496-3331
FAX: (301) 480-9982

INSTRUCTIONS: This form must be completed in its **entirety**, each section must be completed or the form could be returned as invalid.

For more information or to submit this form electronically, please visit our website:
https://clinicalcenter.nih.gov/participate/medicalrecordrequest.html

Please complete a separate form for each requestor

1. PATIENT INFORMATION:

Patient Name:	Phone Number:	Date of Birth:

2. ACTION: Up to two outside care providers can have permanent authorization to obtain copies of medical records. This authorization may be revoked at any time upon your request. If the below named individual is not a healthcare provider, please skip this step.

- ◯ **Add New Care Provider** - Please give the below named care provider access to my medical records.
- ◯ **Replace Authorized Care Provider** - Replace existing care provider _____with the below named care provider.
- ◯ **Remove Authorized Care Provider** - Please remove the below named care provider's access.

3. RELEASE INFORMATION TO: Who do you want to receive the requested records - **Full Mailing Address Required**. Phone and fax are optional. All other fields are required

Name:			Phone #:
Address:			Fax #:
City:	State:	Zip Code:	Country:

4. INFORMATION TO BE RELEASED: *Review options and check appropriate box(es):*

DATES OF SERVICE TO BE RELEASED: From _____ to _____

- ☐ **Clinical Notes**
- ☐ **Radiology Reports**
- ☐ **Radiology Images** (will be released on a CD)
- ☐ **Pathology Reports**
- ☐ **Lab results**
- ☐ **Other Diagnostic Test Results** (Cardiac, Pulmonary Function, Neurological Testing, etc.)
- ☐ **Other (Please Specify)** :

5. THE PURPOSE OR NEED FOR DISCLOSURE (Continued Care, Personal Use,etc):

6. AUTHORIZATION: Permission is hereby granted to the National Institutes of Health Clinical Center to release medical information to the individual/organization as identified above. *Note: submission of this form authorizes future disclosures to the same individual and/or entity within **one year** from date of signature*.

Patient/Authorized Signature	Print Name	Date

Patient Identification *(Staff Use Only)*

Authorization for the Release of Medical Information
NIH-527 (7-21)
P.A. 09-25-0099
File in Section 4: Correspondence