

MEDICAL RECORD**Authorization for the Release of Medical Information**

INSTRUCTIONS: Complete this form in its entirety and forward the original to the address below:
Please complete a separate form for each requestor

**NATIONAL INSTITUTES OF HEALTH
 ATTN: MEDICAL RECORD DEPARTMENT
 MEDICOLEGAL SECTION
 10 CENTER DRIVE, MSC 1192
 BLDG 10, ROOM B1L400
 BETHESDA, MD 20892-1192**

**TELEPHONE: (888) 790-2133 (outside calling area)
 (301) 496-3331 (local calls)
 FACSIMILE: (301) 480-9982**

IDENTIFYING INFORMATION:

Patient Name	Daytime Telephone	Date of Birth
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REQUESTOR INFORMATION: Information is to be released to the following individual or party:

Name	Telephone		
Address	Fax Number		
City	State	Zip Code	Country

*Please note that a patient may designate up to two outside care providers to have permanent authorization to obtain copies of their medical records. This authorization may be revoked at any time upon your request. If you would like the above named care provider to have such access or update existing care providers, please choose one of the following:

- Please give the above named care provider authorization to my medical records
- Please replace _____ (existing authorization) with the above named care provider
- Please remove the above named care provider's authorization

The purpose or need for disclosure: _____

Date Range of Information to be Released: from _____ to _____
 (month/year) (month/year)

Please check specific information to be released:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Nuclear Medicine Reports | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Pulmonary Function Tests | <input type="checkbox"/> Nuclear Medicine CD Images | <input type="checkbox"/> Radiology CD Images |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Tissue Exam Reports | <input type="checkbox"/> Heart Diagnostics | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Outpatient Progress Notes | | | |
- Other (Please Specify):** _____

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 the release of the information specified within **one year** from date of signature.)

Patient/Authorized Signature	Print Name	Date
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