

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
MEDICAL RECORD DEPARTMENT
ATTN: MEDICOLEGAL SECTION
10 CENTER DRIVE, MSC 1192
BLDG 10, ROOM 1N208
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

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"/> Tissue Exam Reports | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Tissue Slides | <input type="checkbox"/> Echocardiogram Reports |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Pulmonary Function Tests | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Outpatient Progress Notes | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Nuclear Medicine Reports |
| <input type="checkbox"/> Consultation Reports
(<i>eye, rehab, etc.</i>) _____ | <input type="checkbox"/> Radiology Films
(<i>CT/x-ray, etc.</i>) _____ | <input type="checkbox"/> Nuclear Medicine Scans
(<i>bone scan, etc.</i>) _____ |

Other (Please Specify): _____

AUTHORIZATION: Permission is hereby granted to the Warren Grant Magnuson 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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If other than patient, specify relationship: _____

Patient Identification	Authorization for the Release of Medical Information NIH-527 (3-02) P.A. 09-25-0099 File in Section 4: Correspondence
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