City/ST/Zip:		City/ST/Zip:	
Phone #:		Fax:	Phone #:	Fax:

Please send medical records by:
First Choice: CD Fax Paper ☐ **NemoursApp** **Email** _____
Second Choice:

Instructions for Form Completion:

Complete Patient Name, Name at Time of Treatment (if different), date of birth, phone, Email, and address. The Medical Record # section will be completed by the HIM Staff.

RELEASING/RECEIVING Medical Records: List the facility/person you wish to Release records in the box on the left and list facility/person you wish or Receive medical records in the box on the right.

Information to be released:

o   Please list the dates of service if applicable

o   Please list the department/s or provider/s if applicable

o   Please identify the specific reports that you are requesting

o   Your initials are required to release the following: You will only receive copies of these type of reports if initials are present.

Purpose of disclosure – Please specify why you are requesting records

Signatures – please review the Authorization section, sign and print your name, enter the date and your relationship to the patient (if the patient is 18 or older – they must sign the Authorization).

o   NOTE: Authorization will expire in 90 days after signature unless otherwise specified *(see #6 under authorization)*.

For questions, please call: 866-956-7299, press option #1

Nemours App

You can sign up for the Nemours app, a secure, confidential, and easy-to-use app/web site that gives patient families 24-hour access to selected parts of their medical records. This **free** program is designed to help patient families easily manage and receive important health information. Get easy access to your child's medical records, see a pediatrician on demand, and check our award-winning educational content to help keep your child healthy.

To get started, download the Nemours app from the Apple App Store or Google Play Store, or visit our website at https://app.nemours.org