TidalHealth Nanticoke recognizes a patient's right under HIPAA to access copies of his/her health information.

TidalHealth Nanticoke
801 Middleford Road; Seaford DE 19973
Phone: (302) 629-6611 Fax: (302) 629-8373

FIN	MRN

TidalHealth Nanticoke

Patient Request for TidalHealth Nanticoke to Release Health Information

Patient Information (Please Print)				
	Patient Name:		**Email Address:**	**DOB:**
	Address:			
	City:	**State:** **Zip:**	**Phone:** ( )	**Cell:** ( )

What records do you want? (Check appropriate boxes below):

(There may be charges associated with producing requested records.)

Office ☐ Notes: ☐ Immunization Records ☐ Medication Lists ☐ Rehabilitation/Therapy Notes ☐ Other: _____

Primary Care: ☐ Bridgeville ☐ Delmar ☐ Federalsburg ☐ Georgetown ☐ Internal Medicine-Seaford ☐ Laurel ☐ Seaford

Specialty Care: ☐ Bariatric & Gen'l Surgery ☐ Diabetes & Endocrinology ☐ Gastroenterology ☐ General Surgery ☐ Infectious Disease ☐ Nephrology ☐ Neurology ☐ Orthopedic ☐ Pulmonary ☐ Urology ☐ Women's Health ☐ Immediate Care

Immediate Care: ☐ Delmar ☐ Georgetown ☐ Laurel ☐ Seaford

Hospital ☐ Consultation Reports ☐ Discharge Summary ☐ Emergency Records ☐ History & Physical ☐ Operative Reports ☐ Entire Record Set (also includes Medication Lists, Nursing Notes, Physician Notes, Physician Orders, Problem Lists, etc)

Testing ☐ Cardiology/Echo/EKG ☐ Lab/Pathology Results ☐ Diagnostic/Radiology Reports

Images ☐ CT _____ ☐ Mammo _____ ☐ MRI _____ ☐ NM _____ ☐ US _____ ☐ XRay _____

Other _____

Note: Sensitive information including Psychiatric/Mental Health, Substance Abuse, HIV or Sexually Transmitted Disease, Pregnancy of a Minor, or Sexual Abuse may be included in the documentation requested.

For Dates of Service beginning: _____/_____/_____ through _____/_____/_____

How would you like your records delivered?

Record Format: ☐ Paper ☐ Electronic DVD ☐ Fax _____ ☐ Other: _____

Deliver by: ☐ US Mail ☐ In person ☐ Email/Web link above ☐ Radiology Dept (fax ROI request to 302-628-6369)

WARNING: TidalHealth Nanticoke does not recommend delivery of Personal Health Information through unsecure email or web links.

Where do you want the information sent? (Fill in boxes below):

☐ Patient/Self; to address above OR ☐ Authorized Representative / Entity (indicated below):

Authorized Representative: **(Only required if patient is not authorized to make health care decisions):**		Relationship to patient:	
Address: (use "SAME" as above if applicable)	City:	State:	Zip:
Phone:	Fax:		

Authorization by Patient or Authorized Representative:

Persons authorized to make health care decisions on an individual's behalf, and requests to release such information, include an adult patient; or a legally authorized representative: legal guardian of a minor; relative caregiver; emancipated minor; married minors; minor parent on the behalf of his/her child; minors enlisted in the service; certain minors if the minor is allowed by State law to consent to the procedure or treatment; certain custodial organizations. The name/identification of the patient or authorized representative below is:

Signature of ☐ Patient OR ☐ Authorized Representative _____	**Signature of Parent or Legal Guardian of Minor 12-18 yrs** _____	**Date:**
Signature of Witness: _____ **Location**: _____		**Date:**
☐ **This authorization was received by phone by:** _____ **(Employee Name)**		**Date:**

This authorization will automatically expire twelve (12) months from the date signed. A photocopy of this authorization will be granted the same authority as the original.

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AUTHORIZATION RECEIVED BY PHONE

This Authorization to Release Health Information was received by phone. I verify that I spoke with the caller, and that the identity of the caller was verified.

☐ Patient ☐ Legal Guardian ☐ Authorized Representative
Guardian Representative Information: License#:_____ Phone:_____
Address:_____
City:_____ State:_____ ZIP:_____

All Patient Demographic Information Must be Verified by Patient or Representative. Compare to most recent demographic information.

☐ Date of birth

☐ Address ☐ Phone

☐ Employer

☐ Who is your insurance carrier? _____

☐ Next of kin _____ matches demographics/facesheet

One Additional Form to Verify Identity Required (or more as needed):

☐ What was the reason for your last visit? _____

☐ Caller ID name matches that of patient

☐ Driver's license or ID #_____ ☐ Verified to other ROI Authorizations

☐ What are the last 4 digits of your social security number?

REQUEST FROM FUNERAL HOME, MEDICAL EXAMINER, GIFT OF LIFE

Reason for Record Request: _____

Name of Company or Other: _____

Contact Person: _____ Phone: _____
