| 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 1N205**
**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 |
|---|---|---|
| | | |

**REQUESTOR INFORMATION:** Information is to be released to the following individual or party:

| Name | Telephone |
|---|---|
| | |
| **Address** | **Fax Number** |
| | |

| City | State | Zip Code | Country |
|---|---|---|---|
| | | | United States |

*****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** _____ **(month/year)** **to** _____ **(month/year)**

**Please check specific information to be released:**

| | | | |
|---|---|---|---|
| ☐ Discharge Summary | ☐ Consultation Reports | ☐ Nuclear Medicine Reports | ☐ Radiology Reports |
| ☐ History & Physical | ☐ Pulmonary Function Tests | ☐ Nuclear Medicine CD Images *(bone scan, etc.)* | ☐ Radiology CD Images *(CT/x-ray, etc.)* |
| ☐ Operative Reports | ☐ Tissue Exam Reports | ☐ Heart Diagnostics | ☐ Lab Results |
| ☐ 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 |
|---|---|---|
| | | |

| Patient Identification | Authorization for the Release of Medical Information<br>NIH-527 (9-08)<br>P.A. 09-25-0099<br>File in Section 4: Correspondence |
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