

DELAWARE MEDICAL GROUP, LLC
Mill Creek Select
Kevin W. O'Hara MD, FACP
2006 Limestone Rd., Suite 3
Wilmington, DE 19808
Phone: (302) 995-2090 Fax: (302) 995-1121

Authorization for Release of Information

I, _____ Date of Birth _____ currently living at
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____

Authorize: _____ to release to:
Name & Address of Organization Releasing Info

Name and Address of Organization Receiving Information:

Mill Creek Select
2006 Limestone Rd., Suite 3
Wilmington, DE 19808

The requested information will be used for:

() Continued Care/Consultation/2nd opinion () Personal () Other () Attorney () Insurance
Regarding the physician services: from _____ to _____

I authorize the release of the following information to Mill Creek Medical Associates:

- | | |
|---|---|
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Drug/Alcohol abuse information |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Mental Health records |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Hospital records |
| <input type="checkbox"/> HIV/Sexually transmitted disease information | |

I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of my medical information requested to the agency or person specified above. I understand that I may revoke this authorization at any time by written request from my designated representative or myself.

This consent shall remain in effect for ninety (90) days from the date executed unless revoked earlier by me. If revoked earlier, all parties understand that the information released prior to being notified of such revocation was made at my request with my consent.

I have read the above and foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent.

Date _____ Signature _____
(If signed by representative, state relationship/authority to do so)

Date _____ Signature _____
(Witness)

THE FOLLOWING APPLIES ONLY TO DRUG/ALCOHOL ABUSE OR TREATMENT INFORMATION RECORDS:
Prohibition on Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation 42-CR-2 prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.