

Instructions on how to complete the NIH Authorization for the Release of Medical Information (NIH-527) form

*All fields on this form are **required***

Identifying Information:

- Patient Name
- Phone Number
- Birth Date

Check Boxes – Only applicable for Outside Care Provider(s)

Only outside care providers may have permanent authorization. Family members, friends, and acquaintances are not permitted.

Date Range:

Specify the start and end date range of records you want to be released. If you don't remember the exact dates, it is acceptable to give a month/year or just the year.

Patient Identification:

This section will be filled out by the NIH Clinical Center Staff.

MEDICAL RECORD		Authorization for the Release of Medical Information	
<small>INSTRUCTIONS: Complete this form in its entirety and forward the original to the address below: Please complete a separate form for each requester.</small>			
<small>NATIONAL INSTITUTES OF HEALTH ATTN: HEALTH INFORMATION MANAGEMENT DEPARTMENT MEDICOLEGAL SECTION 10 CENTER DRIVE, MSC 1192 BLDG 10, ROOM B1L400 BETHESDA, MD 20892-1192</small>		<small>TELEPHONE: (888) 790-2133 (outside calling area) (301) 496-3331 (local calls) FACSIMILE: (301) 480-9982</small>	
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
<small>*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:</small>			
<input type="checkbox"/> Please give the above named care provider authorization to my medical records <input type="checkbox"/> Please replace _____ (existing authorization) with the above named care provider <input type="checkbox"/> 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:			
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Nuclear Medicine Reports	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Pulmonary Function Tests	<input type="checkbox"/> Nuclear Medicine CD Images (bone scan, etc.)	<input type="checkbox"/> Radiology CD Images (CT/X-ray, etc.)
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Tissue Exam Reports	<input type="checkbox"/> Heart Diagnostics	<input type="checkbox"/> Lab Results
<input type="checkbox"/> Other (Please Specify): _____			
<small>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.)</small>			
Patient/Authorized Signature		Print Name	Date
Patient Identification		Authorization for the Release of Medical Information NIH-527 (7-18) P.A. 09-25-0099 File in Section 4: Correspondence	

Requestor Information:

The person or place to receive copies of your medical records.

A full mailing address is required.

- Requestor Name
- Street Address
- City
- State
- Zip Code
- Telephone
- Fax (if applicable)

Purpose or Need for Disclosure:

Write in the purpose for this request (ex. continuation of care, personal use, etc).

Information to be Released:

Identify the category of records you would like to have released by checking the corresponding boxes. If the records you are requesting are not listed, please indicate those specific records on the blank line next to the "Other (Please Specify):" selection.

Patient/Authorized Signature: Over 18 years old, only you can sign here. Under 18 years old, your parent or legal guardian must sign this form. Signatures must be drawn and not typed.

There are situations in which this general rule does not apply. For inquiries regarding individuals who are authorized to sign this form, please contact the Health Information Management Department at 888-790-2133.

Authorizations are valid for one year (unless revoked by the patient) and must be dated.

If you have any other questions about filling out this form please contact the Health Information Management Department's Medicolegal Section at 888-790-2133. Our business hours are 7am-5pm EST Monday-Friday, excluding federal holidays.