REQUEST FOR MEDICAL INFORMATION FROM SOURCE OUTSIDE THE NATIONAL INSTITUTES OF HEALTH

INSTRUCTIONS: Complete this form in its entirety and forward to the Medical Record Department, Medicolegal Section, Building 10, Room 1N205 (1-888-790-2133). ALL REQUESTS MUST REFERENCE FORMALLY REGISTERED PATIENTS OF THE NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER (CC).

CC PATIENT IDENTIFICATION

(Patient Name) _____ (Patient Number) _____ (Date of Birth) _____

SOURCE OF INFORMATION REQUESTED

(Name of Health Care Organization or Physician) _____ (Phone Number) _____ (Fax Number) _____

(Street Address) _____ (City) _____ (State) _____ (Zip Code) _____

The purpose or need for disclosure: _____

When requesting MILITARY RECORDS, please furnish:

(Sponsor Name) _____ (Sponsor Social Security Number) _____

INFORMATION REQUESTED

Identify the specific items and related dates pertaining to the information to be released.

1. Medical Reports _____

Send to: National Institutes of Health
Clinical Center
_____ (Name of Department)
Building 10, Room _____ (Room Number)
10 CENTER DRIVE MSC _____ (Mail Stop Code)
BETHESDA, MD 20892-_____ (Mail Stop Code)
ATTENTION:_____ (Name of Requesting Physician)

2. X-Ray Films and X-ray Reports _____

Send to: National Institutes of Health
Clinical Center
Diagnostic Radiology Department
Building 10, Room 1C506
10 CENTER DRIVE MSC 1182
BETHESDA, MD 20892-1182

3. Pathological Slides _____

Send to: National Institutes of Health
Clinical Center
Laboratory of Pathology
Building 10, Room 2B50
10 CENTER DRIVE MSC 1500
BETHESDA, MD 20892-1500

AUTHORIZATION

I hereby authorize the release of the above-requested medical information.

(Signature of Patient/Legal Guardian) _____ (Printed Name of Patient) _____ (Date Signed) _____

(Street Address) _____ (City) _____ (State) _____ (Zip Code) _____