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

*All fields on this form are required*

**1. Patient Information:**
- Patient Name
- Phone Number
- Birth Date

**2. Action** – *Only applicable for Outside Care Provider(s)*

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

**4. Information to be Released :**
Specify the start and end dates of service for records that 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.

**5. Purpose or Need for Disclosure:**
Write in the purpose for this request (ex. continuation of care, personal use, etc).

| MEDICAL RECORD | Authorization for the Release of Medical Information |
|---|---|

National Institutes of Health, Clinical Center
Health Information Management Dept.
10 Center Drive, MSC 1192
Building 10, Room B1L400
Bethesda, MD 20892-1192
Phone: (888) 790-2133 or (301) 496-3331
FAX: (301) 480-9982

**INSTRUCTIONS:** This form must be completed in its entirety, each section must be completed or the form could be returned as invalid.

For more information or to submit this form electronically, please visit our website:
https://clinicalcenter.nih.gov/participate/medicalrecordrequest.html

*Please complete a separate form for each requestor*

**1. PATIENT INFORMATION:**

| Patient Name: | Phone Number: | Date of Birth: |
|---|---|---|
| | | |

**2. ACTION:** Up to two outside care providers can have permanent authorization to obtain copies of medical records. This authorization may be revoked at any time upon your request. If the below named individual is not a healthcare provider, please skip this step.

- ○ **Add New Care Provider** - Please give the below named care provider access to my medical records.
- ○ **Replace Authorized Care Provider** – Replace existing care provider __________ with the below named care provider.
- ○ **Remove Authorized Care Provider** - Please remove the below named care provider's access.

**3. RELEASE INFORMATION TO:** Who do you want to receive the requested records - **Full Mailing Address Required**. Phone and fax are optional. All other fields are required.

| Name: | | | Telephone: |
|---|---|---|---|
| Address: | | | Fax Number: |
| City: | State: | Zip Code: | Country: |

**4. INFORMATION TO BE RELEASED:** *Review options and check appropriate box(es):*

**DATES OF SERVICE TO BE RELEASED:** From ______________ to ______________

- ☐ Clinical Notes
- ☐ Radiology Reports
- ☐ Radiology Images (will be released on a CD)
- ☐ Pathology Reports
- ☐ Lab Results
- ☐ Other Diagnostic Test Results (Cardiac, Pulmonary Function, Neurological Testing, etc.)
- ☐ Other (Please Specify)______________________________

**5. THE PURPOSE OR NEED FOR DISCLOSURE** (Continued Care, Personal Use, etc): ______________________

**6. 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 future disclosures to the same individual and/or entity within one year from date of signature.*

| Patient/Authorized Signature | Print Name | Date |
|---|---|---|
| | | |

Patient Identification *(Staff Use Only)*

Authorization for the Release of Medical Information
NIH-527 (7-21)
P.A. 09-25-0099
File in Section 4: Correspondence

**3. Release Info To:**
*The person or place to received copies of your medical records.*
*A full mailing address is required.*
- Requestor Name
- Street Address
- City
- State
- Zip Code
- Telephone
- Fax (if applicable)

**4. Information to be Released (Continued):**
Indicate what 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.

**6. Patient/Authorized Signature:** If you are 18 years of age or older, you are the only person who is permitted to sign this form. If you are under the age of 18, your parent or legal guardian must sign this form. 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 888-780-2133.

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.*