Clinical Nurse Consultants
Authorization for Release of Medical Information

PATIENT'S NAME: ____

DATE OF BIRTH:__________________________

I hereby authorize my primary care provider(s), including but not limited to **Christiana Care (CCHS), Bayhealth, Saint Francis Hospital, Delaware rehabilitation facilities, specialty physicians, and any other treating clinicians or healthcare facilities**, to release the health information requested below to the person or entity identified herein. I further authorize the discussion and disclosure of my **protected health information (PHI)** with the individual or entity named below and consent to the release and production of any medical records requested.

Current or Previous Primary Care Physician:_______________________________
____

RECEIVING PARTY:

Clinical Nurse Consultants

710 Wilmington Rd Suite 3
Historic New Castle De 19720

Phone: 302-507 -2201
Fax: 302-209-6655

INFORMATION REQUESTED:

_____ Medical records

_____Other (Please specify): ________________

BY SIGNING THIS AUTHORIZATION FORM, I UNDERSTAND THAT:

I may be charged reasonable cost-based fees as allowed by law, for all postage and copying costs and other agreed-upon special services.

© 2026 ALL RIGHTS RESERVED Clinical Nurse Consultants

Information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by the federal privacy requirements, including HIPAA, 45 C.F.R., part 164.

This authorization permits the release of information which may be related to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services and/or treatment for alcohol and/or drug abuse.

I have the right to revoke this authorization at any time by sending a written revocation to the above-specified entity, but that this authorization cannot be revoked to the extent that protected health information has been previously provided in reliance on this document.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected under federal HIPAA regulations. The releasing provider is not responsible for any further disclosure once the information has been released as authorized.

A copy of this authorization may be used as an original. This authorization may remain valid for a maximum period of one year following the signature date unless otherwise noted.

________________ ____

Date Signature of Patient or Legal Representative

____

Printed Name

____

Legal Relationship to Patient (Please attach documentation in support of authority)

© 2026 ALL RIGHTS RESERVED Clinical Nurse Consultants

Clinical Nurse Consultants
"Care That Comes To You"

Clinical Nurse Consultants
"Care That Comes To You"