Release of Medical information Request

How can I get my records?

To get or send a copy of your medical records, diagnostic imaging (x-ray, CT scan, MRI) CD's, or pathology slides, fill out the *Release of Medical Information Form* on the other side of this page.

You can then mail or fax the form to the Medical Records Department.

If you would like to pick up your records in person, you will need to call ahead.

Important Information

General:

- You must fill out all sections that are bolded if they apply to you. Please print clearly.
- We cannot send medical information to private fax numbers, only to the office of a doctor, or healthcare center.
- There is no fee for records we send to your doctor or healthcare center.
- There may be a fee for copies of records for your personal use. You will need to pay this fee before we give you the records.
- We will do our best to get your records to you within 7-10 business days.
- If you need your records for your ongoing care, we will send them to outside care providers once we get a request.
- We are not able to accept electronic signatures.
- If you are picking up your records, you will need to show us a valid ID (driver's license, state I.D., passport, hospital I.D. wristband, etc.). You may send someone on your behalf; but you must put their information on the release form that you sign. They will also need to show proper ID.

Diagnostic Imaging: We can only give you imaging done at Fox Chase Cancer Center (FCCC). Our imaging department does not keep outside CD's.

If you are asking for CD's, you must fill out this form which we will send to Diagnostic Imaging Records, **and** you must call them directly at 215-728-3879.

Pathology Slides: Our Pathology Department only sends slides directly to a doctor or healthcare center. Please fill out the section with the receiver's information.

If you are asking for slides, you must fill out this form which we will send to the Pathology Department, **and** you must call them directly at 215-728-3675.

Contact Information:

Fox Chase Cancer Center
333 Cottman Avenue
Philadelphia, PA 19111

Medical Records Department
Phone: 215-728-2640
Fax: 215-728-1122

Diagnostic Imaging Records
Phone: 215-728-3879
Fax: 215-214-1663

Hours: Monday-Friday 8am-4pm

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Fox Chase Cancer Center ● 333 Cottman Avenue ● Philadelphia, Pa 19111

Medical Records Dept.: Phone: 215-728-2640 Fax: 215-728-1122

Diagnostic Imaging File Room: Phone: 215-728-3879 Fax: 215-214-1663

This form authorizes Fox Chase Cancer Center to release information regarding the following patient to the person indicated below.

PLEASE PRINT and COMPLETE ALL **BOLDED** FIELDS WHERE APPLICABLE

Patient Name: **Date of Birth:**

Medical Record Number (if known): **Phone Number:** **SS Number: xxx-xx-**

Name of person who will receive or who will pick up the medical records:

Address:

Phone Number: **Fax Number** (For Physician or Healthcare Facility only)**:**

Medical records request: Please check the information requested and include dates of service.

- ☐ History and Physical from _____
- ☐ Operative report from _____
- ☐ Laboratory results from _____
- ☐ Outside test results from _____
- ☐ Visit/Progress Notes from _____
- ☐ Discharge summary from _____
- ☐ Imaging reports from _____
- ☐ Pathology reports from _____
- ☐ Chemotherapy records from _____
- ☐ Radiation Therapy records from _____
- ☐ Other, please specify: _____ from _____

Diagnostic Imaging request: If requesting diagnostic imaging CD's, please complete following section.
Date(s) of service with the imaging type_____
CD's containing diagnostic images are produced by Diagnostic Imaging Records. You can contact them directly by phone at 215-728-3879 or via fax at 215-214-1663.

Pathology request: If requesting pathology slides, please provide the information for the recipient of the slides.
Name of recipient_____ Phone number of recipient_____
Address of recipient_____
The Pathology Departments requires 48 hours advanced notice for slides. Please call them at 215-728-3675.

Purpose of disclosure: ☐Continuing Care/second opinion/referring physician ☐Insurance/disability ☐Personal use

Date records needed by: _____ Our standard is to provide medical records within 7-10 business days. When required for continuing care, medical records will be sent to outside care providers upon receipt of request.

Authorization:

● I understand that there may be a fee that must be paid prior to my receiving copies of records for my personal use.
● I understand that this information, except for action already taken, is subject to revocation by me at any time. This authorization will automatically expire within 60 days. I am aware that this information may be sent via fax only to another health care provider.
● I authorize FCCC to use or disclose the health information noted above including information regarding my treatment, hospitalization, and/or outpatient care for my condition(s), including genetic consult/results, psychological or psychiatric condition(s), alcohol and/or drug abuse, or any HIV-related information; (In accordance with Federal confidentiality rules (42 CFR Part 2), State Mental Health Procedures Act and Act 148).

Patient Signature:	**Date:**
***Signature of authorized person in lieu of patient:**	***Date:**
***Authorized person's relationship to patient:**	

*If the patient is incapacitated or underage and cannot sign the authorization, the patient's legal guardian may sign in lieu of the patient with proof of guardianship or POA. If the patient has expired, the executor of the estate may sign with substantiating documentation.

----------FCCC USE----------

Faxed copy of request to: □ File Room Date_____ □Pathology Date_____□ Medical Records Date _____

Signature checked using: □Photo ID □Recent Consent □Other (specify)

_____

Rev 9/2008, 10/2009, 9/2010, 12/2010, 2/2012, 7/2012, 3/2014, 4/2014, 5/2015, 4/2017, 5/2019, 6/2019 , 7/2023