

**DREXEL UNIVERSITY PHYSICIANS®
ELECTRONIC MEDICAL RECORD
BREAK THE GLASS STATUS REQUEST FORM**

I am requesting that my electronic medical record with Drexel University Physicians® and that of my immediate family members listed below be accorded Break the Glass status.

PATIENT NAME	DATE OF BIRTH	HOME ADDRESS

Employee or Student Name: _____

Employee Signature: _____ **Date:** _____

Phone number where you can be reached during the day: _____

- I am employed by:**
- Drexel University College of Medicine
 - Drexel University
 - Tenet (including house staff)

- I am a student at:**
- Drexel University College of Medicine

Please return completed form to: **Director of Patient and Clinical Office Services
Drexel University Physicians
1601 Cherry Street, Suite 11498
Philadelphia, PA 19102
Fax: 215-255-7308**

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