ChristianaCare™

RAUTH

Wilmington Hospital HIMS
501 W. 14th St., Wilmington, DE 19801
Phone: 302-320-6852
Fax: 302-320-4692

REQUEST FOR ACCESS TO HEALTH INFORMATION

Subsidiary: _____

Instruction:
To be completed when an individual requests to inspect or receive a copy of their record.
If this request is to provide health information to a person other than the patient, use Authorization to Release Health Information form instead.

NOTICE: Patients are generally entitled to access their medical and billing record upon request and/or may sign up for access through the Patient Portal. ChristianaCare will respond to the request for copies of the record within thirty (30) days (with one thirty (30) day extension when necessary). ChristianaCare may deny the request for certain reasons specified by law. If ChristianaCare denies the request, the requester will be informed of the reason. The patient may be permitted to have the denial decision reviewed by the ChristianaCare Privacy Office. In addition, ChristrianaCare will notify the requester in advance of the cost of receiving copies of the record.

PLEASE COMPLETE ONE FORM FOR EACH ACCESS REQUESTED

Patient name (print): _____ Date of birth: _____ /_____ /_____

Address: _____

_____

Email: _____

(required for any electronic copy)

Purpose for access: _____

I would like access to the following documents/records (specify):

☐ Entire Record (Note: Only records of visits within the last ten (10) years are available per ChristianaCare Record Retention policy.)
☐ Admission History and Physical ☐ Pathology Reports ☐ Provider Notes
☐ Discharge Summary ☐ Radiology Reports ☐ Emergency Department Notes
☐ Operative Reports ☐ Laboratory Reports
☐ Other (specify): _____

SPECIAL AUTHORIZATIONS FOR SUBSTANCE ABUSE TREATMENT, HIV/STD RESULTS, AND/OR PSYCHOLOGICAL and PSYCHIATRIC TREATMENT RECORDS (mark and initial each area you are authorizing):

☐ I specifically request access to information pertaining to genetic information. _____ (initial)
☐ I specifically request access to information pertaining to substance abuse treatment. _____ (initial)
☐ I specifically request access to information pertaining to psychological and psychiatric treatment. (For psychotherapy notes, a separate form is required.) _____ (initial)
☐ I specifically request access to information pertaining to HIV/STD treatment and test results. _____ (initial)

Date(s) of visit (specify): _____

_____

How do I want to receive the information (mark only one)?

☐ Electronic copy (e.g., compact disk, thumb drive) via: ☐ Mail ☐ Pick-up
☐ Secure email ***(only possible if under 50 pages)***
☐ Paper copy via: ☐ Mail ☐ Pick-up
☐ Review in person

For pick-up, I would like to pick up at the following location:
☐ Christiana Hospital ☐ Wilmington Hospital ☐ Union Hospital ☐ Provider office: _____ (specify)
(**Note:** Government-issued Photo Identification, such as a driver's license, is required at time of pick-up)

I understand that there is a fee charged for copies and postage needed to release the medical records, and the fees have been explained to me.

_____ (_____) _____ -_____ _____ /_____ /_____
Signature of Patient Phone # Date

OR, if patient is not able/capable to sign:

_____ _____ (_____) _____ -_____ _____ /_____ /_____
Signature of Legal Representative Print Name Phone # Date

_____
Relationship to Patient

Interpretation: The information has been presented to the: ☐ Patient ☐ Representative ☐ Decision Maker in: _____ Language
The person who provided the interpretation is a qualified medical interpreter.

_____ _____
Interpreter Name Agency and ID# (if applicable)

_____ _____ ___/___/___ _____
Witness Signature/Title Print Name or ID# Date Time

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REQUEST FOR ACCESS TO HEALTH INFORMATION

Side 2 - For Christiana Care Use Only

Instruction:
Privacy Department Use Only.

DEPARTMENT

Request received by: _____ on: _____ /_____ /_____

Extension requested (if applicable) on: _____ /_____ /_____

Access provided by: _____ on: _____ /_____ /_____

Or

Request referred to Privacy Office by: _____ on: _____ /_____ /_____

Comments: _____

_____

_____

_____

PRIVACY OFFICE

Requested received by:_____ on: _____ /_____ /_____

Extension requested (if applicable) on: _____ /_____ /_____

Request reviewed by: _____ on: _____ /_____ /_____

☐ Approved ☐ Denied

If denied, reason for denial: _____

Patient or Legal Representative notified on: _____ /_____ /_____

If denied, second review completed by: _____ on: _____ /_____ /_____

☐ Approved ☐ Denied

Patient or Legal Representative notified of decision on: _____ /_____ /_____

If access approved, access provided by:_____ on: _____ /_____ /_____

Comments: _____

_____

_____

_____