CHRISTIANA CARE

RAUTH

AUTHORIZATION TO REQUEST HEALTH INFORMATION

Instruction:
Complete this form when requesting health information from other healthcare provider(s).

PLEASE COMPLETE ALL AREAS OF THIS FORM

Patient/member name (print): _____ **Date of birth:** ____/____/____

I authorize Christiana Care to REQUEST my health information from:	**Send via:** ☐ **Mail** ☐ **Fax** ☐ **Call** ☐ **VPN line** **TO:**
_____ (Name and Organization)	_____ (Name and Organization)
_____ (Street address)	_____ (Street address)
_____ (City, State, Zip Code)	_____ (City, State, Zip Code)
ATTN: _____	ATTN: _____
Telephone: _____	Telephone: _____
Fax: _____	Fax: _____

These records are needed for the following reason: _____

The following information is needed (specify): _____

_____

In reference to the following:

Date(s) of Visit	Location, Department, Type of Service

Expiration of this authorization.
This authorization expires in 180 days OR upon the following date or event: _____
(specify date or event)

Revoking this authorization. This authorization may be revoked at any time but is not retroactive for requests that have been complied with in good faith. To revoke this authorization, please provide a written request to the department releasing your information.

_____ _____ ____/____/____ **or,**
Signature of Patient/Member Telephone No. Date

_____ _____ ____/____/____
Signature of Legal Representative and Relationship to Patient/Member Telephone No. Date

The organization providing records will not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization.

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 Print Name Date Time