ChristianaCare

RAUTH

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Subsidiary/Department: Christiana Care Pediatric Associates

Address: 4735 Ogletown-Stanton Road

Medical Arts Pavillion 2, Suite 1116

Telephone: ( ) Newark, DE 19713

Instruction:
To be completed when health information is being released from Christiana Care.

PLEASE COMPLETE ALL AREAS OF THIS FORM

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

I authorize Christiana Care to release and/or give copies of my health information to:

_____
(Name and Organization)

_____
(Street address)

_____
(City, State, Zip Code)

ATTN: _____ Tel. No.: _____

These records are needed for the following reason: ☐ Medical care ☐ Legal consult ☐ Insurance review
☐ Other (specify): _____

The following information is to be released: ☐ Medical records ☐ X-Ray/Imaging ☐ Financial records
☐ Other (specify): _____

In reference to the following:

Date(s) of Visit	Location, Department, Type of Service, Type of Record, etc.
/ /	
/ /	
/ /	

Please list any specific information that is needed: _____

I am specifically authorizing the release of the following: ☐ Genetic Information (describe above) ☐ Substance Abuse Treatment
☐ HIV Treatment (does not include HIV testing result) ☐ Psychological and Psychiatry Treatment (Psychotherapy notes require additional consent)

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.

I understand the recipient will be charged for copies and postage and in turn the recipient may ask to be reimbursed by me.

_____ _____ ( ) _____
Signature of Patient or Legal Representative | Relationship to Patient, if Legal Representative | Telephone No.

____/____/____ _____
Date | Time

Christiana Care will not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization. Information, once released, may no longer by protected by Federal Privacy Rules and may be subject to redisclosure by the recipient. However, information covered under Federal Regulations 42 CFR Part 2 may not be redisclosed unless expressly permitted by the authorization or the regulations.

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

A photocopy of the signed authorization form is as valid as the original.