ChristianaCare™

RAUTH

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.

***PLEASE COMPLETE ONE FORM FOR EACH ACCESS REQUESTED ***

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

Address: _____

_____

Telephone: (____)_____ Email address: _____
(required for any electronic copy)

Purpose for access: _____

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

□ Admission History and Physical	□ Pathology Reports	□ Provider Report
□ Discharge/Transfer Summary	□ Radiology Reports	□ Emergency Department
□ Operative Reports	□ Laboratory Reports	□ Entire Record (within the last ten (10) years)

□ Other (please specify):_____

THERE ARE SPECIAL AUTHORIZATIONS REQUIRED FOR DRUG/ALCOHOL, HIV/STD RESULTS, AND/OR PSYCHIATRIC TREATMENT RECORDS:

□ I specifically authorize access to information pertaining to genetic information. _____ (initials)

□ I specifically authorize access to information pertaining to drug/alcohol and or psychiatric treatment. _____ (initials)

□ I specifically authorize access to information pertaining to HIV/STD Test Results. _____ (initials)

How do I want to receive my information?

□ 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

(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.

_____ (____)_____ ____/____/____
Signature of Patient | Telephone Number | Date

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

_____ _____ (____)_____ ____/____/____
Signature of Legal Representative | Relationship to Patient | Telephone Number | Date

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

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Side 2 - For Christiana Care 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

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

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

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

□ Approved □ Denied

If denied, reason for denial: _____

Individual notified on:_____/_____/_____

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

□ Approved □ Denied

Individual notified of decision on:_____/_____/_____

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

Comments: _____

_____

_____

_____