ChristianaCare

RAUTH

AUTHORIZATION TO REQUEST HEALTH INFORMATION

Instruction:
To be completed when health information is being requested from other healthcare provider(s).

MRN: _____

PLEASE COMPLETE ALL AREAS OF THIS FORM

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

I authorize ChristianaCare to REQUEST my health information from:

_____
(Name and Organization)

_____
(Street address)

_____
(City, State, Zip Code)

ATTN: _____ Telephone: _____ Fax: _____

Send via: ☐ Mail ☐ Fax ☐ Call
TO:

_____
(Name and Organization)

_____
(Street address)

_____
(City, State, Zip Code)

ATTN: _____ Telephone: _____ Fax: _____

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

The following information is needed (specify): ☐ Medical records ☐ Insurance review ☐ 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 request of the following:
☐ Genetic Information (**describe above**) ☐ Substance Abuse Treatment ☐ HIV treatment (**does not include HIV testing result**)
☐ Psychological and Psychiatry Treatment (**Psychiatry 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.

X _____ _____ X ____/____/____ or,
Signature of Patient — Telephone No. — Date

_____ _____ ____/____/____
Signature of Legal Representative and Relationship to Patient — 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