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.

MRN: _____

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

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

Address: _____

_____

Telephone: (_____) _____ Email address: _____

Purpose for access: _____

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

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

I am specifically authorizing the release of the following:

☐ Genetic Information ☐ Substance Abuse Treatment ☐ HIV Treatment (does not include HIV testing result)
☐ Psychological and Psychiatry Treatment (Psychotherapy notes require additional consent of your doctor)

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

☐ CD (Compact Disk) via: ☐ Mail ☐ Pick-up at: ☐ Christiana Hospital or ☐ Wilmington Hospital
☐ Email ***(only possible if under 50 pages)***
☐ Paper copy via: ☐ Mail ☐ Pick-up at: ☐ Christiana Hospital or ☐ Wilmington Hospital
☐ Review in person

(Note: 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 and my request may take 5 - 10 business days to process.

X _____ **X** (_____) _____ **X** ____/____/____
Signature of Patient — Telephone Number — Date

OR, if patient is not able/capable 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