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CHRISTIANA CARE
HEALTH SERVICES

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** **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.