ChristianaCare™

RAUTH

Wilmington Hospital HIMS
501 W. 14th St., Wilmington, DE 19801
Phone: 302-320-6852
Fax: 302-320-4692

REQUEST FOR ACCESS TO HEALTH INFORMATION

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: _____

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.

_____ (_____) _____ _____ /_____ /_____
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

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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

Requested 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: _____

_____

_____

_____