ChristianaCare™

RAUTH

AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH INFORMATION

Subsidiary/Department: _____

Address: _____

_____

Telephone: (_____) _____

Instruction:
To be completed when health information is being released from Christiana Care.

PLEASE COMPLETE ALL AREAS OF THIS FORM

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

Family Member(s) 1. _____ 2. _____ 3. _____
Friend(s) 1. _____ 2. _____ 3. _____

I hereby authorize ChristianaCare to release and/or give copies of my health information to:

_____
(Name and Organization)

_____
(Street address)

_____
(City, State, Zip Code)

ATTN: _____ Tel. No.: _____

I hereby authorize ChristianaCare to verbally communicate my health information to:

_____
(Name and Organization)

_____
(Street address)

_____
(City, State, Zip Code)

ATTN: _____ Tel. No.: _____

These records are needed for the following reason: □ Medical care □ Legal consult □ Insurance review

□ Other (specify): _____

I understand the specific type of information to be disclosed includes (please initial each):

_____ Discharge Summary
_____ Physical Exam & History
_____ Psychological Testing
_____ Psychiatric Progress Note(s)
_____ School/Educational Records

_____ Initial Assessment
_____ Medical Orders
_____ Aftercare Plan
_____ Date(s)
_____ PRP Contact Note(s)

_____ Treatment Plan Dates
_____ Rehab Plan Dates
_____ Lab/Testing Report
_____ Other _____ Referral
_____ Date(s)

Other (please specify): _____

In reference to the following:

Date(s) of Visit (within the last ten (10) years	Location, Department, Type of Service, Type of Record, etc.
/ /	
/ /	
/ /	

Please list any specific information that is needed: _____

_____

_____

By signing below, I understand and acknowledge the following:

- That authorizing the disclosure of this health information is voluntary.
- That I may refuse to sign this authorization.
- That I do not need to sign this form in order to receive treatment
- That this authorization at any time by presenting a written revocation to the department releasing your information.
- That I do not have a right to revoke this authorization if it was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest a claim under the policy of the policy itself.
- That any revocation will not apply to information that already has been released in response to this authorization.
- That any disclosure of information carries with it the potential for an unauthorized disclosure, and the information may not be protected by confidentiality rules.
- That ChristianaCare will not condition treatment on my signing this authorization unless (1) I am enrolled in a research study and the treatment is part of that study, or (2) the sole purpose of health care is to disclose health information to someone else.
- That the fees for copying and mailing the information have been explained to me, and I understand that I will be responsible for the costs of copying and mailing.
- That if I have any questions about disclosure of my protected health information, I may contact the HIMS Department.

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.

I understand the recipient will be charged for copies and postage and in turn the recipient may ask to be reimbursed by me.

_____ _____ (_____) _____

Signature of Patient or Legal Representative | Relationship to Patient, if Legal Representative | Telephone No.

_____ /_____/_____ _____

Date | Time

Christiana Care will not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization.
Information, once released, may no longer by protected by Federal Privacy Rules and may be subject to redisclosure by the recipient. However, information covered under Federal Regulations 42 CFR Part 2 may not be redisclosed unless expressly permitted by the authorization or the regulations.

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

A photocopy of the signed authorization form is as valid as the original.