RAUTH

AUTHORIZATION TO RELEASE 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:________/______/______

I 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.: ______________________

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

◻ Other (specify): ______________________________

The following information is to be released (check all applicable):

◻ Admission History and Physical
◻ Discharge/Transfer Summary
◻ Operative Reports
◻ Pathology Reports
◻ Radiology Reports
◻ Laboratory Reports
◻ Provider Report
◻ Emergency Department
◻ Entire Record (within the last ten (10) years)
◻ Other (please specify):______________________________

THERE ARE SPECIAL AUTHORIZATIONS REQUIRED FOR DRUG/ALCOHOL, HIV/STD RESULTS, AND/OR PSYCHIATRIC TREATMENT RECORDS:

◻ I specifically authorize the disclosure of information pertaining to genetic information. _______________ (initials)

◻ I specifically authorize the disclosure of information pertaining to drug/alcohol and or psychiatric treatment. _______________ (initials)

◻ I specifically authorize the disclosure of information pertaining to HIV/STD Test Results. ________________ (initials)

By signing below, I understand and acknowledge the following:

- That I may revoke 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 information released pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- 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

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