



RAUTH

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Subsidiary/Department: _____

Address: _____

Telephone: (_____) _____

Instruction:
To be completed when health information is being released from Christiana Care. Side 1 of 2

PLEASE COMPLETE ALL AREAS OF THIS FORM

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

I authorize Christiana Care 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: Medical records X-Ray/Imaging Financial records

Other (specify): _____

In reference to the following:

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

Please list any specific information that is needed: _____

I am specifically authorizing the release of the following: Genetic Information (describe above) Substance Abuse Treatment
 HIV Treatment (does not include HIV testing result) Psychological and Psychiatry Treatment (Psychotherapy notes require additional consent)

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 _____

ChristianaCare will not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization. Information, once released, may no longer be 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: _____
The person who provided the interpretation is a qualified medical interpreter. Language _____

Interpreter Name _____ Agency and ID# (if applicable) _____

Witness Signature _____ Print Name _____ Date ____/____/____ Time _____

