CHRISTIANA CARE

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

RAUTH

AUTHORIZATION TO RELEASE HEALTH INFORMATION

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 Christiana Care to release and/or give copies of my health information to:

Records Deposition Service
(Name and Organization)

27355 W. Eleven Mile Rd
(Street address)

Southfield, MI 48033
(City, State, Zip Code)

ATTN: Records Tel. No.: 248-357-3330

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 ______

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.