



CHRISTIANA CARE

**AUTHORIZATION TO
RELEASE
HEALTH INFORMATION**

Subsidiary: _____

MR# _____

Complete this form when health information is being released from Christiana Care

Acct# _____

*** 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

Please list any specific information that is needed:

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.

Signature of Patient/Member Telephone No. _____ Date _____ **OR,**

Signature of Legal Representative & Relationship to Patient/Member Telephone No. _____ Date _____

Christiana Care 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.

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