ChristianaCare™

CNSNT

Patient name:

Date of birth:

Attending physician:

AUTHORIZATION TO VERBALLY RELEASE INFORMATION FROM PHYSICIAN OFFICE

I understand that my personal healthcare information is protected under the Health Insurance Portability and Accountability Act (HIPAA). I authorize Christiana Care to VERBALLY disclose the information I have marked to the individuals identified below.

Name	Relationship	Contact Phone Number
☐ Scheduling/Appointment information	☐ Billing and payment information/ Financial status	☐ Medical information (i.e.; diagnoses, medications, immunizations, treatment plans)
☐ General test results (i.e. lab, x-ray, MRI, pathology	☐ Sensitive test results (i.e.; STD, HIV, Cancer, OB/GYN)	☐ Behavioral Health conditions

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Expiration and Revocation:
This authorization expires one year from the date it is signed. I understand this authorization may be revoked at any time but is not retroactive for information that has been shared in good faith and prior to this authorization being revoked. To revoke this authorization, I understand that I must provide a written request to the office releasing my information.

Christiana Care will not condition treatment, payment, enrollment or eligibility for benefits on the completion of this authorization. Once released, the information 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.

In addition to the disclosure authorized by this form, I understand that Christiana Care will use and disclose my information for treatment, payment, and healthcare operations, and as allowed by applicable law and as stated in the Notice of Privacy Practices.

____________________ ____________________ ____/____/____ ________

Signature of Patient or Decision Maker | Relationship to Patient | Date | Time

____________________ ____________________ ____/____/____ ________

Witness Signature | Witness Print Name | Date | Time

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

Key: CFR - Code of Federal Regulations HIV - Human Immunodeficiency Virus MRI - Magnetic Resonance Imaging OB/GYN - Obstetrics/Gynecology STD - Sexually Transmitted Disease