



RAUTH

REQUEST FOR ACCESS TO HEALTH INFORMATION

Subsidiary: \_\_\_\_\_

Instruction:

To be completed when an individual requests to inspect or receive a copy of their record.

If this request is to provide health information to a person other than the patient, use

Authorization to Release Health Information form instead.

Side 1 of 2

NOTICE: Patients are generally entitled to access their medical and billing record upon request and/or may sign up for access through the Patient Portal. ChristianaCare will respond to the request for copies of the record within thirty (30) days (with one thirty (30) day extension when necessary). ChristianaCare may deny the request for certain reasons specified by law. If ChristianaCare denies the request, the requester will be informed of the reason. The patient may be permitted to have the denial decision reviewed by the ChristianaCare Privacy Office. In addition, ChristianaCare will notify the requester in advance of the cost of receiving copies of the record.

\*PLEASE COMPLETE ONE FORM FOR EACH ACCESS REQUESTED\*

Patient name (print): \_\_\_\_\_ Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

(required for any electronic copy)

Purpose for access: \_\_\_\_\_

I would like access to the following documents/records (specify):

- Entire Record (Note: Only records of visits within the last ten (10) years are available per ChristianaCare Record Retention policy.)
Admission History and Physical
Discharge Summary
Operative Reports
Other (specify):
Pathology Reports
Radiology Reports
Laboratory Reports
Provider Notes
Emergency Department Notes

SPECIAL AUTHORIZATIONS FOR SUBSTANCE ABUSE TREATMENT, HIV/STD RESULTS, AND/OR PSYCHOLOGICAL and PSYCHIATRIC TREATMENT RECORDS (mark and initial each area you are authorizing):

- I specifically request access to information pertaining to genetic information.
I specifically request access to information pertaining to substance abuse treatment.
I specifically request access to information pertaining to psychological and psychiatric treatment.
I specifically request access to information pertaining to HIV/STD treatment and test results.

Date(s) of visit (specify): \_\_\_\_\_

How do I want to receive the information (mark only one)?

- Electronic copy (e.g., compact disk, thumb drive) via: Mail Pick-up
Secure email (only possible if under 50 pages)
Paper copy via: Mail Pick-up
Review in person

For pick-up, I would like to pick up at the following location:

- Christiana Hospital
Wilmington Hospital
Union Hospital
Provider office: \_\_\_\_\_ (specify)

(Note: Government-issued Photo Identification, such as a driver's license, is required at time of pick-up)

I understand that there is a fee charged for copies and postage needed to release the medical records, and the fees have been explained to me.

Signature of Patient (Phone #) - Date / /

OR, if patient is not able/capable to sign:

Signature of Legal Representative Print Name (Phone #) - Date / /

Relationship to Patient

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/Title Print Name or ID# Date / / Time



RAUTH

### REQUEST FOR ACCESS TO HEALTH INFORMATION

**Instruction:**

Privacy Department Use Only.

Side 2 of 2

**DEPARTMENT**

Request received by: \_\_\_\_\_ on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Extension requested (if applicable) on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Access provided by: \_\_\_\_\_ on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Or**

Request referred to Privacy Office by: \_\_\_\_\_ on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Comments: \_\_\_\_\_

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**PRIVACY OFFICE**

Requested received by: \_\_\_\_\_ on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Extension requested (if applicable) on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Request reviewed by: \_\_\_\_\_ on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Approved     Denied

If denied, reason for denial: \_\_\_\_\_

Patient or Legal Representative notified on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If denied, second review completed by: \_\_\_\_\_ on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Approved     Denied

Patient or Legal Representative notified of decision on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If access approved, access provided by: \_\_\_\_\_ on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Comments: \_\_\_\_\_

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