CHRIAS
Christiana Institute of Advanced Surgery

Christiana Institute of Advanced Surgery

Dear Patient,

We have received your request for a form or note to be completed.

In order for us to facilitate your request, we will need the following information:

1. If you need a form to be completed, please send us the form if you have not done so. For faster service, please send it to us via the patient portal. You may also fax forms to 302.892.9980.

2. If you only need a note and you do not need a form to be completed. Please indicate below who we should address it to and how you would like to receive:

   □ Send form or note to: _____ Fax: _____

   □ Send form to me via patient portal

3. Please complete and return this form as well as the Patient Authorization for Disclosure of Health Information form via the patient portal for faster service. You may also fax these forms to 302.892.9980.

4. Indicate below the dates you are requesting to be excused from work:

   (From: _____ To: _____)

5. Date you are requesting to return to work: _____

Please return these completed forms to us as soon as possible. We will facilitate your request as soon as we receive all the information marked above. Please allow ten business days from the date we receive all the required information for processing.

Thank you for your attention to this matter.

In Health,

Patient Service Representative Department

Christiana Institute of Advanced Surgery

Patient Authorization for Disclosure of Health Information

Patient Name :_____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____

I request that my protected health information (PHI) from **Christiana Institute of Advanced Surgery P.A**. be disclosed to:

Recipient Name: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

I authorize the following PHI to be released from my medical record(s) including, but not limited to diagnoses, lab results, treatment and billing records for all conditions. I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and federal laws protect the following information: (**If this information applies to you, please indicate if you would like this information released/obtained)**

□ Alcohol, Drug, or Substance Abuse Records
□ Communicable diseases including but not limited to HIV and AIDS
□ Mental Health
□ Genetic Information

Purpose for requesting information: □ Legal □ Insurance □ Personal □ Continuation of Care □ Other: _____

Disclosure Method: □ Hard Copy □ Electronic Copy **Delivery Method:** □ Mail □ Fax □ Electronically

By signing this authorization form, I understand that:

• Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
• I understand that I may inspect a copy of the copy of the records being disclosed.
• I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: **537 Stanton Christiana Road Suite 102 Newark DE 19713.** Revocation will not apply to information that has already been disclosed in response to this authorization.
• Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire 3 months after the date of this authorization.
• Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
• Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.
• Marketing: Financial remuneration will be received by a third party for marketing purposes.
• Sale of PHI: Remuneration will be received for disclosure of my health information.
• I understand that there may be a fee for copying or supplying medical records. (Fee schedules are set forth by the Delaware Division of Professional Regulation.)

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

Note: A minor's signature is required for release of information related to reproductive care, sexually transmitted diseases, and drug alcohol or substance abuse and mental health treatment.

Minor's Signature: _____ Date: _____