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: ____________________________