DELAWARE DEPARTMENT OF CORRECTION
RELEASE OF INFORMATION AUTHORIZATION

Name: _____ **SBI**: _____ **Date of Birth**: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

I am either the patient named above or the patient's legally authorized representative. If signing in a representative capacity, I have attached hereto legal proof of my representative status (e.g., power or attorney, letters testamentary, letters of administration, etc.). By signing this form, I authorize and release the Contract Provider _____ the Delaware Department of Correction and their respective employees, officers and agents from liability relating to the release of the following information, including protected health information included in my medical records.

Information to be released from the dates: _____ to: _____
(start date) (end date)

Records or Information to be released:

- ☐ **I only authorize the release of copies of my records specifically checked below (check all that apply)**
- ☐ **I am not requesting copies of my records to be released but I am authorizing the below mentioned parties to discuss those records specifically checked below.**

☐ **Admission Records**	☐ **Medical History/Records**	☐ **Mental Health Evaluations**
☐ **Diagnostic Reports**	☐ **Medical Screenings & Assessments**	☐ **Psychiatric Evaluations**
☐ **Discharge Reports**	☐ **Medications (please attach list)**	☐ **Substance Use History & Evaluations**
☐ **HIV Status and Treatment**	☐ **STD Status and Treatment**	☐ **Treatment Plan**
☐ **Immunization History**	☐ **Behavioral Health Screenings & Assessments**	☐ **Other (specify):**

Disclosure is being made for the purpose(s) listed below:

☐ **Legal**	☐ **Judicial/Courts**	☐ **Medical**
☐ **Insurance**	☐ **Other (Specify):**	

Records released from:
Name/Agency: _____
Address: _____
Phone Number: _____

Records released to:
Name/Agency: _____
Address: _____
Phone Number: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, and/or drug and/or alcohol use. If I have authorized the release of records by checking one or more of the boxes above, you are hereby specifically authorized to release all healthcare information relating to such testing, diagnosis, and/or treatment of the after mentioned conditions. I understand that my records are protected under Federal privacy regulations with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and Federal Regulation governing Confidentiality of Alcohol and Drug Abuse patient Records 42 CFR, Part 2, if applicable. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may disclose it to others, and that any information disclosed by the BCHS Healthcare Provider may no longer be protected by HIPAA. However, federal confidentiality regulations, 42 CFR, Part 2, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or the substance abuse treatment program. I understand medical records cannot be disclosed without the written consent, except as provided for under federal or state law. I also understand that I will be charged $.10 per page for any personal, family, or attorney requests, per Delaware Administrative Code, Title 24: Chapter 1700, Section 29.

This authorization expires and becomes invalid on the following date: _____, or one year from the date of execution if no date is specified, and is subject to revocation by me at any time if provided in writing to the Department of Correction, Bureau of Healthcare, Substance Abuse, and Mental Health Services (BHSAMH), except to the extent that disclosure has been made in reliance on this authorization prior to receipt of such revocation. To be valid, notice of revocation must be signed by me and delivered to _____.

I understand I am not required to sign this authorization to receive healthcare treatment. I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by applicable privacy laws and could be re-disclosed by the person or agency that receives it. I do not authorize such secondary disclosure with respect to any records protected by 42 CFR, Part 2. State law provides that a healthcare provider may charge a reasonable fee for these records. Upon the request of the Department of Correction, any personal representative must show documentation of the legal basis for the relationship to the patient prior to any record production.

Signature of patient or authorized representative: _____ Date: _____

AUTHORIZED REPRESENTATIVE'S NAME AND RELATIONSHIP TO PATIENT WHO HAS THE AUTHORITY TO ACT FOR PATIENT:

Printed Name: _____ Relationship: _____

My signature below verifies my refusal in the release of any and all information to the above named individual:

Signature of patient or authorized representative: _____ Date: _____

Revised May 2020