



University of North Carolina Health Care System
101 Manning Drive, Chapel Hill, NC 27514
(919) 966-2336, Fax (919) 966-6295
ATTENTION: RELEASE OF MEDICAL INFORMATION

AUTHORIZATION FORM - MIM #710-(s)

I authorize:

UNC Health Care System

OR

Other:

To use or disclose to: _____
 Name _____ Address _____
 City _____ State _____ Zip Code _____
the protected health information of

Patient Name: _____ Date of Birth: ____/____/____
 Address: _____ City: _____ State: _____ Zip Code _____
 Telephone: (____) _____ Social Security # (voluntary): _____
 UNC HCS Medical Record # _____ Treatment Dates: _____

Information to be disclosed (please initial below to indicate information requested):

<input type="checkbox"/> Clinic Notes	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Consultations
<input type="checkbox"/> Emergency Dept. Notes	<input type="checkbox"/> Operative/Procedure Notes	<input type="checkbox"/> Discharge Summary	Other: <i>PHOTOGRAPHS</i>
<input type="checkbox"/> Urgent Care Center Notes	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Lab Reports	
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Medical Orders	<input type="checkbox"/> X-Ray Reports	

I acknowledge that the data to be released MAY INCLUDE information protected by law. My initials below authorizes inclusion of information pertaining to:

<input type="checkbox"/> Mental Health	<input type="checkbox"/> Drugs & Alcohol	<input type="checkbox"/> HIV/ AIDS, Other Communicable Diseases	<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> Not Applicable
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The purpose of the use or disclosure is:

<input type="checkbox"/> Attorney/ Legal	<input type="checkbox"/> Continued Patient Care	<input type="checkbox"/> Insurance
<input type="checkbox"/> Personal Use	<input type="checkbox"/> Social Services/ Disability	<input type="checkbox"/> Other:

Continue on Reverse

Please check box that applies:

	Mail to above address.
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	Pick up records.
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	Review records in Release of Information department at hospital (No printed copies).
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I understand that:

- I may revoke this Authorization at any time:
 - the revocation will not apply to information that has already been released in response to this Authorization
 - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the Medical Information Management Department.
- I may refuse to sign this Authorization:
 - UNC Health Care System will not condition my treatment, any payment, enrollment in a health plan, or eligibility for benefits on receiving my signature on this Authorization.
- a fee may be charged for copying the protected health information

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ . If I fail to specify an expiration date or event or condition, this authorization will expire automatically in ninety (90) days from the date of signature.

I have read and understand the information in this Authorization form.

Signature of Patient:	
Printed Name:	Date:

OR

Signature of Authorized Representative:	
Printed Name:	Date:
Please explain Representative's authority to act on the behalf of the Patient:	

Office Use Only			
Ed. On Fee: _____	Call for: _____	Pickup: _____	Review