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 check below to indicate information requested):

	Clinic Notes		Progress Notes		Nurses Notes		Consultations
	Emergency Dept. Notes		Operative/Procedure Notes		Discharge Summary	Other:	
	Urgent Care Center Notes		Pathology Reports		Laboratory Reports		
	History and Physical		Medical Orders		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:

	Mental Health		Drugs & Alcohol		HIV/ AIDS, Other Communicable Diseases		Genetic Testing		Not Applicable

The purpose of the use or disclosure is:

	Attorney/ Legal		Continued Patient Care		Insurance
	Personal Use		Social Services/ Disability		Other:

Continue on Reverse

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