UNC HEALTH CARE

500 Eastowne Drive
Chapel Hill, NC 27514

AUTHORIZATION FORM – MIM #710-S

☐ Radiology Films please send:

ATTN: IMAGING SUPPORT
(919) 966-3280, Fax (919) 966-4990

☐ For all other record requests please send:

ATTN: RELEASE OF MEDICAL INFORMATION
(919) 966-2336, Fax (919) 966-6295
Email: relmedinfo@unch.unc.edu

I authorize:

	UNC Health Care System	OR		Other facility:

To use or disclose to:

Name of Person or Facility:			
Address	City	State	Zip
Phone:	Fax:	Email:	

The protected health information of:

Patient Name:		Date of Birth:	SS# (last 4):
Address	City	State	Zip
Phone:		UNC Medical Record #	

Dates of Service: _____

Put a <u>CHECKMARK</u> next to the specific documents that apply to your request:

	Clinic notes (outpatient)		Operative / Procedure notes		Progress Notes (inpatient)
	Emergency Dept. notes		Providers Orders		Radiology reports
	Urgent Care Center notes		Nursing notes		Patient Billing records
	History and Physical		Consultations		Film / CD (Imaging support)
	Discharge Summary		Laboratory reports		All Medical Records
Other (describe)					

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing. This authorization does not include permission to release psychotherapy notes (defined as records from private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical record). Release of psychotherapy notes requires a separate authorization.

Put a <u>CHECKMARK</u> next to the purpose of the request:

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

Put a <u>CHECKMARK</u> next to how you would like to receive your request:

	Mail to address listed above.
	Review in Release department.
	Receive electronically at e-mail above

	Fax to # listed above **(Health care providers only; no personal faxes)**
	Review remotely **(employees only)**

	Pick up in Release Dept.
	Verbal release

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:
  - My treatment, payment, enrollment in a health plan, or eligibility for benefits can not be conditioned upon my authorization of this disclosure.
  - A fee may be charged for providing the protected health information. Please contact Copy Service to obtain fee and rate information at 919-966-4521.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure 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	
PROCESSED DATE: _____ PROCESSED BY:_____ ADDITIONAL NOTES:	STAMPS / ADDITIONAL NOTES: