



# AUTHORIZATION FORM – HIM #710-S

500 Eastowne Drive  
Chapel Hill, NC 27514

☐ Radiology Films please send:

ATTN: IMAGING SUPPORT  
(984) 974-9362, Fax (984) 974-8814  
Email: FILMmail@unchealth.unc.edu

☐ For all other record requests please send:

ATTN: RELEASE OF MEDICAL INFORMATION  
(984) 974-3226, Fax (984) 974-0471  
Email: relmedinfo@unchealth.unc.edu

## I authorize:

	UNC Health Care System
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OR

	Other facility:
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## 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 **CHECKMARK** next to the specific documents that apply to your request:

<input type="checkbox"/>	Clinic notes (outpatient)	<input type="checkbox"/>	Operative / Procedure notes	<input type="checkbox"/>	Progress Notes (inpatient)
<input type="checkbox"/>	Emergency Dept. notes	<input type="checkbox"/>	Providers Orders	<input type="checkbox"/>	Radiology reports
<input type="checkbox"/>	Urgent Care Center notes	<input type="checkbox"/>	Nursing notes	<input type="checkbox"/>	Patient Billing records
<input type="checkbox"/>	History and Physical	<input type="checkbox"/>	Consultations	<input type="checkbox"/>	Film / CD (Imaging support)
<input type="checkbox"/>	Discharge Summary	<input type="checkbox"/>	Laboratory reports	<input type="checkbox"/>	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 **CHECKMARK** next to the purpose of the request:

<input type="checkbox"/>	Attorney/ Legal
<input type="checkbox"/>	Personal Use

<input type="checkbox"/>	Continued Patient Care
<input type="checkbox"/>	Social Services/ Disability

<input type="checkbox"/>	Insurance
<input type="checkbox"/>	Other:



Put a **CHECKMARK** next to how you would like to receive your request:

<input type="checkbox"/>	Mail to address listed above.
<input type="checkbox"/>	Review in Release department.
<input type="checkbox"/>	Receive electronically at e-mail above

<input type="checkbox"/>	Fax to # listed above <b>(Health care providers only; no personal faxes)</b>
<input type="checkbox"/>	Review remotely <b>(employees only)</b>

<input type="checkbox"/>	Pick up in Release Dept.
<input type="checkbox"/>	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 Health 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 984-974-3584.

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:	Time:

Or

Signature of Authorized Representative:		
Printed Name:	Date:	Time:
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:
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