UNC REGIONAL PHYSICIANS
UNC HEALTH CARE

Medical Records Release Form

I do hereby consent and authorize UNC Regional Physicians to release copies of my medical records.

Patient Name _____ Medical Record Number _____

Address | *Street Number or RFD* _____

City, State and Zip Code _____ Phone _____

Date of Birth _____ Social Security Number | *Last 4 digits only* XXX - XX- _____

RECORDS REQUESTED FROM UNC REGIONAL PHYSICIANS

Name of Person or Facility _____

Practice Address | *Street Number or RFD* _____

City, State and Zip Code _____ Phone _____

Email _____ Fax _____

RECORDS TO USE OR DISCLOSE TO

Name of Person or Facility _____

Practice Address | *Street Number or RFD* _____

City, State and Zip Code _____ Phone _____

Email _____ Fax _____

Please select all the specific documents that apply to your request:

- ☐ Clinic Notes
- ☐ Radiology Reports
- ☐ Nurses Notes
- ☐ Emergency Room
- ☐ Progress Notes
- ☐ Lab Reports
- ☐ Operative Reports
- ☐ Doctor Consults
- ☐ History & Physical
- ☐ Pathology Reports
- ☐ EKG, EEG, EMG
- ☐ Physician Orders
- ☐ Discharge Summary
- ☐ Urgent Care
- ☐ Other _____

Please place your *initials* beside the options below to authorize the release of sensitive information pertainting to:

Mental Health _____ Drugs or Alcohol _____ Not Applicable: None of these apply _____

Genetic Testing _____ HIV/AIDS/other infectious diseases _____

Please select the purpose of your request:

- ☐ Continued Patient Care
- ☐ Attorney/Legal
- ☐ Insurance
- ☐ Social Service/Disability
- ☐ Worker's Compensation
- ☐ Personal
- ☐ Other _____

Please select how you would like to receive your request:

- ☐ Mail to address above
- ☐ E-mail
- ☐ Verbal
- ☐ Pick up at Practice
- ☐ **URGENT:** Fax to number listed above

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Patient Name _____ Medical Record Number _____

I UNDERSTAND:

☐ 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 UNC Regional Physicians.

☐ I may refuse to sign this Authorization:
- My treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned upon my authorization of this disclosure.
- A fee may be charged for copying the protected health information. Please see the Practice Manger for information.

I have been informed and understand the 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.

_____

Patient Signature Date

_____

Printed Name of Patient

_____

Signature of Authorized Representative Date

_____

Printed Name of Authorized Representative

_____

Please explain Respresentative's authority to act on behalf of the Patient

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Office Use Only

Date Processed _____ Stamps/Additional Notes _____

Processed By _____ _____