



UNC
HOSPITALS

For Radiology Films please send:
ATTN: FILM MANAGEMENT
(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

**UNC Health Care System
101 Manning Drive, Chapel Hill, NC 27514
RELEASE OF MEDICAL INFORMATION AUTHORIZATION FORM – MIM #710-S**

I authorize:

	UNC Health Care System
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OR

	Other:
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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 Sec. # (last 4 digits only): _____

UNC HCS Medical Record # _____ TREATMENT DATES: _____

Put a CHECKMARK next to the specific documents that apply to your request:

	Outpatient Clinic Notes
	Emergency Dept. Notes
	Urgent Care Center Notes
	History and Physical

	Inpatient Progress Notes
	Operative/Procedure Notes
	Pathology Reports
	Provider Orders

	Nurses Notes
	Discharge Summary
	Laboratory Reports
	Radiology Reports

	Consultations
	Film / CD
	Other:

Put your INITIALS next to any SENSITIVE information that pertains to your request.

	Mental Health
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	Drugs & Alcohol
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	HIV/ AIDS, Other Communicable Diseases
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	Genetic Testing
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	Not Applicable
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Put a CHECKMARK next to the purpose of the request:

	Attorney/ Legal
	Personal Use

	Continued Patient Care
	Social Services/ Disability

	Insurance
	Other:

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

<input type="checkbox"/> Mail to above address.	<input type="checkbox"/> Pick up records.	<input type="checkbox"/> 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. Please contact Copy Service to obtain fee and rate information @ 919-966-4521

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:	
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Office Use Only

Ed. On Fee: _____ Call for: _____ Pickup _____ Review _____