



AUTHORIZATION FORM – MIM #710-S

101 Manning Drive
Chapel Hill, NC 27514

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:
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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:	Birth date:	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) _____		

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

NOTE: Initial only the boxes below that are applicable. Do NOT initial "Not Applicable" unless none of the first 4 boxes apply.

<input type="checkbox"/> Mental Health	<input type="checkbox"/> Drugs or Alcohol	<input type="checkbox"/> HIV / AIDS or other communicable diseases	<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> N/A
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Put a CHECKMARK next to the purpose of the request:

<input type="checkbox"/> Attorney/ Legal	<input type="checkbox"/> Continued Patient Care	<input type="checkbox"/> Insurance
<input type="checkbox"/> Personal Use	<input type="checkbox"/> Social Services/ Disability	<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"/>	Receive Electronically
<input type="checkbox"/>	Review in Release Dept.

<input type="checkbox"/>	Fax to # listed above (Urgent or Prioritized)
<input type="checkbox"/>	Review remotely (UNC HCS employees only)

<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 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 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 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: