THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

HIPAA Consent for Release of Information
[Department Name]
[Address]

I,_____, authorize:

☐	Department Name:	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	☐	Operative / Procedure notes	☐	Progress Notes (inpatient)
☐	Emergency Department	☐	Providers Orders	☐	Radiology reports
☐	Urgent Care	☐	Nursing notes	☐	Patient Billing records
☐	History	☐	Consultations	☐	Film / CD (Imaging support)
☐	Discharge Summaries	☐	Laboratory reports	☐	All Medical/Dental Records

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol, 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
☐	Personal Use

☐	Continued Patient Care
☐	Social Services/ Disability

☐	Insurance
☐	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 cannot be conditioned upon my authorization of this disclosure.

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: