AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Important-Please mail records if over 10 pages

UNC PHYSICIANS NETWORK
UNC HEALTH CARE

I authorize: (Check One)

☐	**UNC Physicians Network, LLC d/b/a :**
☐	Name of Person or Facility:
	Address, City, State, ZIP:
	Phone: / Fax: / Email:

To use or disclose to:

Name of Person or Facility:		
Address, City, State, ZIP:		
Phone:	Fax:	Email:

The MEDICAL RECORD (Protected Health Information) **OF:**

Patient Name:		Date of Birth:
Address, City, State, ZIP:		
Phone:	Medical Record #:	SSN (last four):
Treatment Dates From:	to	

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

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

Place your **initials** in the applicable boxes below to authorize the release of **SENSITIVE** information pertaining to:

	Mental Health		Drugs & Alcohol		HIV/AIDS/ other infectious diseases		Genetic Testing		Not Applicable: None of these apply

Put a CHECKMARK next to the purpose of the request:

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

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

☐	Mail to address above.	☐	E-Mail	☐	Verbal	☐	Fax to # listed above (Urgent or Prioritized)	☐	Pick up at Practice

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 UNC Physicians Network, LLC Compliance Manager.
- 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 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:
Signature of Authorized Representative:	
Printed Name:	Date:
Please explain Representative's authority to act on the behalf of the Patient:	
OFFICE USE ONLY	
Processed Date: _____ Processed By: _____	Stamps / Additional Notes: Rev 11.2012