**UNC FERTILITY**

7920 ACC BLVD SUITE 300

RALEIGH, NC 27617

PHONE: (919) 908-0000 FAX: (919) 596-6147

**RELEASE OF MEDICAL INFORMATION**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(Please **PRINT** your name)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Record Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (s) of Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_**Patient Portal**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of doctor or hospital **RELEASING** information) (Name of doctor or hospital **RECEIVING** information)

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  | Clinical Notes |
|  | Emergency Notes |
|  | Urgent Care Notes |
|  | History & Physical |

**Information to be disclosed (please initial information requested)**

|  |  |
| --- | --- |
|  | Progress Notes |
|  | Pathology Report |
|  | Medical Orders |
|  | Procedure Notes |

|  |  |
| --- | --- |
|  | Nurses Notes |
|  | Lab Reports |
|  | X-Ray Reports |
|  | Discharge Summary |

|  |  |
| --- | --- |
|  | Consultations |
|  | Other: |
|  |  |
|  |  |

**I acknowledge that the data to be released MAY INCLUDE information protected by law.**

**My initials below authorizes inclusion of The purpose of the use or disclosure is:**

|  |  |
| --- | --- |
|  | Attorney / Legal |
|  | Personal Use |
|  | Continued Patient Care |
|  | Insurance |
|  | Social Services |
|  | Disability |
|  | Other: |

**information pertaining to:**

|  |  |
| --- | --- |
|  | Mental Health |
|  | Drugs & Alcohol |
|  | Genetic Testing |
|  | HIV/AIDS, other Communicable Diseases |

Continue on Reverse

**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 writing revocation to the Medical Information Management Department.
* I may refuse to sign this Authorization:
  + UNC Health Care Systems will not condition my treatment, ant 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.

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, event, or condition, this authorization will expire in ninety (90) days from the date of signature.

**I have read and understand the information in the Authorization form:**

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

(Please **SIGN** your name)

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please **PRINT** your name)

**OR**

Signature of Authorized

Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please PRINT your name)

Please explain Authorized Representative’s Authority to act on behalf of the Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |
| --- |
| **For Office Use Only**  Ed. On Fee \_\_\_\_\_\_\_\_\_\_\_  Call for \_\_\_\_\_\_\_ Pickup \_\_\_\_\_\_\_\_ Review |