UNC FERTILITY

7920 ACC BLVD SUITE 300

RALEIGH, NC 27617

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RELEASE OF MEDICAL INFORMATION

Patient Name _____ Date of Birth _____/_____/_____
(Please PRINT your name)

Address _____ Medical Record Number _____

_____ Date (s) of Treatment _____

I authorize _____ To _____
(Name of doctor or hospital RELEASING information) (Name of doctor or hospital RECEIVING information)

Address _____ Address _____

_____ _____

Information to be disclosed (please initial information requested)

	Clinical Notes
	Emergency Notes
	Urgent Care Notes
	History & Physical

	Progress Notes
	Pathology Report
	Medical Orders
	Operative / 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 information pertaining to:

	Mental Health
	Drugs & Alcohol
	Genetic Testing

	HIV/AIDS, other Communicable Diseases

The purpose of the use or disclosure is:

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

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

_____

_____

_____

_____

For Office Use Only

Ed. On Fee _____

Call for _____ Pickup _____ Review