thrive Campus Health Services
Campus Health Services at the University of North Carolina at Chapel Hill
CB #7470 | (p) 919.966.2281 | (f) 919.966.0616 | campushealth.unc.edu

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ PID #: _____ DOB: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Phone #: (___) _____ Email: _____

I request and authorize: ☐ UNC Campus Health Services **OR** ☐ Other: _____

To release the Protected Health Information of the patient named above to:

☐ UNC Campus Health Services ☐ Other: Name:_____

☐ Patient: Address: _____

☐ Mail to Address above _____

☐ Pick-up Fax #: _____ Phone: _____

☐ E-mail: _____

Information to be Released

☐ Billing Records

☐ Counseling and Psychological (CAPS) Records

☐ Entire Record (excludes CAPS records)

☐ Immunization Records (including titer results)

☐ Prescription History

☐ X-Ray Films

☐ Other: _____

Purpose of the Release

☐ Attorney/Legal

☐ Continued Patient Care

☐ Insurance

☐ Parental/Guardian Communication

☐ Personal Use

☐ Other: _____

Treatment/service date(s) for requested information: _____

I acknowledge that the information to be released MAY INCLUDE information protected by law. My initials below authorize inclusion of information pertaining to:

____ Mental Health _____ Substance Abuse _____ HIV/Other Reportable STIs _____ Not Applicable

Continue on Reverse →

Patient Name: _____ PID #: _____

I understand that:

1. 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 Health Information Management Department.
2. I may refuse to sign this Authorization:
   - UNC Campus Health services will not condition my treatment, any payment, or eligibility for benefits on receiving my signature on this Authorization.
3. 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 redisclosure 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 of Patient	Date

OR if patient is under the age of 18

_____	_____	_____
Signature of Parent/Guardian	Printed Name of Parent/Guardian	Date

Forward Completed Form To:

University of North Carolina at Chapel Hill
Campus Health Services
ATTENTION: Health Information Management
CB # 7470, Chapel Hill, NC 27599-7470
Fax (919) 966-0616
Email: immunizations@unc.edu

Office Use Only

□ Request Approved
□ Request Denied

Date Completed: _____

Completed By:_____

Number of Pages Copied: _____
- □ Mailed
- □ Faxed
- □ Emailed
- □ Patient Pick-Up