AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ PID #: _____

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

Phone #: (___) _____ Email: _____

I request and authorize:

☐ UNC Campus Health OR ☐ Other: Name:_____

Address: _____

Fax #: _____ Phone: _____

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

☐ UNC Campus Health ☐ Other: Name:_____

☐ Patient Address: _____

Fax #: _____ Phone: _____

How information is to be released:

☐ Patient Pickup ☐ Mail to address above ☐ Fax to number above ☐ Email to address above

Information to be Released

☐ Billing Records

☐ Counseling and Psychological (CAPS) Records

☐ Entire Record (excludes CAPS records)
(includes progress notes, lab reports, x-ray reports, immunization records)

☐ Immunization Records Only (including titer results)

☐ Prescription History

☐ 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 understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.

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 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 (Electronic signatures not accepted)	Printed Name of Patient	Date

OR if patient is under the age of 18

_____	_____	_____
Signature of Authorized Representative (Electronic signatures not accepted)	Printed Name	Date

Please explain Representative's authority to act on behalf of Patient: _____

Forward Completed Form To:

Campus Health, CB # 7470
University of North Carolina at Chapel Hill
ATTN: Health Information Management
Chapel Hill, NC 27599-7470
Fax (919) 966-0616 | Phone (919) 966-2283
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