M3132
Rev. 8/16

Duke Health

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Label
Patient Name
Medical Record #
Account #
Date of Birth

Release From:

☐ Duke University Hospital ☐ Duke Raleigh Hospital ☐ Duke Regional Hospital ☐ Duke Eye Center ☐ Davis Ambulatory Service Center (DASC)
☐ Duke Primary Care (specify location:_____) ☒ Private Diagnostic Clinic (PDC) (Specify name: Carolina Family Practice and Sports Medicine
☐ ALL DHE Entities ☐ Other (describe): _____

Action Requested:

☐ Provide a copy of my Health Information to: ☐ I request to view my Health Information onsite (I do not want a copy)
☐ Discuss my Health Information with:

Name_____ Phone_____ Fax _____

Address _____
Street City State Zip

How would I like the records or Health Information to be released? (for other options call #919-684-1700)

FORMAT (check one): ☐ Paper copy ☐ Electronic copy (CD) ☐ Electronic copy (flash drive) ☐ MyChart

DELIVERY: ☐ Mail ☐ Fax ☐ In Person Pick up (NAME OF PERSON) _____
☐ Oral Communication ☐ Encrypted Email: (enter address clearly)_____

Purpose:

☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal ☐ Other (specify)_____

Treatment Date(s):

☐ Treatment dates from_____to_____ (Please be specific) OR ☐ ALL Treatment Dates

Information to be Released: (check reports below)

☐ ENTIRE RECORD ☐ Summary Information (Discharge Summary, Operative Notes/ Procedure Notes, Radiology, Pathology, Laboratory, EKG, ED Notes, Clinic Visits, Consults)	☐ History & Physical ☐ Radiology Reports ☐ Laboratory Reports ☐ Pathology Reports ☐ Clinic Notes (Ambulatory ☐ Operative Report	☐ ED Record ☐ Discharge Summary ☐ Immunization Records ☐ PT/OT Notes	☐ Discharge Instructions ☐ Clinic Notes (Ambulatory Progress Notes) ☐ Other (specify)

☐ **Information contained in the Patient's medical record related to psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment to date. (May require physician approval.)**

☐ **Information contained in the Patient's medical record related to treatment for alcohol and/or drug abuse.**

I Understand That:

- ***The information to be released may include a diagnosis or reference to the following conditions: sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV).***
- Without my express revocation, this Authorization will automatically expire one year from the date signed below, unless I request an expiration date less than one year.
- I may **revoke** this Authorization in writing at any time, except to the extent that action has already been taken to comply with it. Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation.
- Information disclosed pursuant to the Authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Signature: My signature is required to validate this Authorization. This Authorization is voluntary. If I do not sign this Authorization, Duke University, Duke University Health System, and the Private Diagnostic Clinic, PLLC will still provide treatment and seek payment for services provided. According to the North Carolina General Statutes, Health Information Management may charge for copies of medical records. **This Authorization will expire on** _____.

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_____ _____ _____
Signature of Patient/Guardian/Personal Representative Date Relationship (parent, guardian, etc.)

_____
Witness

If you are not the patient, you MUST attach documentation of your authority to act on behalf of the patient. (other than parent).

Send request to the applicable entity address or fax listed below or **email to: ROI-requestor3@dm.duke.edu. For questions: 919-684-1700**

Duke University Hospital, DASC, DPC clinics, PDC clinics H.I.M. Box 3016 Durham, NC 27710 Fax: 919-620-5165	**Duke Raleigh Hospital** H.I.M. 3301 Executive Drive MOB5, 2nd floor Raleigh, NC 27609 Fax: 919-620-5165	**Duke Regional Hospital** H.I.M. 3643 N Roxboro Road Durham, NC 27704 Fax: 919-620-5165	**Duke Eye Center** Email: EyeCente-MedicalRecords@dm.duke.edu H.I.M. PO Box 101005 Durham, NC 27710 Fax: 919-681-1013 • Phone: 919-684-3588