DukeHealth

# AUTHORIZATION FOR RELEASE OF INFORMATION

## PART A: PATIENT INFORMATION

Patient Name: Phone: Email:

Address:

Date of Birth: SS# (last 4 digits): Medical Record #:

## PART B: PERSON OR COMPANY WHO WILL RECEIVE INFORMATION

☐ Self (same info as above)

☐ Person or Entity:_____ Phone:_____ Email:_____

Address:_____ Fax:_____

## PART C: INFORMATION TO BE RELEASED (check all that apply)

**Records or Information:**

| | | | |
|---|---|---|---|
| ☐ Abstract/Summary (Discharge Summary, Operative/Procedure Notes, Pathology, Laboratory, ED Notes, Clinic Visits, Consults) | ☐ Discharge Summary<br>☐ History and Physical<br>☐ Consultation Report<br>☐ Operative Report<br>☐ Laboratory Reports<br>☐ Pathology Reports | ☐ Radiology Reports<br>☐ Radiology Images<br>☐ Physical/Occupational Therapy<br>☐ Immunization Record<br>☐ Emergency Department Record | ☐ Clinic Visit<br>Specify Provider/Clinic ____<br>_____<br>☐ Other (please specify) _____ |
| ☐ Entire Record<br><br>☐ Billing Records | | | |

**Treatment Location:**

| | | |
|---|---|---|
| ☐ All Duke Health Enterprise Entities | ☐ Duke University Hospital<br>☐ Duke Raleigh Hospital | ☐ Duke Regional Hospital<br>☐ Duke Clinic (specify provider / location) CFP & SM |

**Treatment Date(s):**

☐ From _____ to _____ (please be specific) ☐ All Treatment Dates

## PART D: PURPOSE OF REQUEST

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

## PART E: FORMAT AND DELIVERY OF INFORMATION

| Format (select only one) | Other | Delivery Method (select only one) |
|---|---|---|
| ☐ MyChart ☐ Encrypted Email ☐ Paper<br>☐ CD ☐ Thumb drive (flash drive) ☐ Fax | ☐ Oral Communication | ☐ Electronic (MyChart, encrypted email)<br>☐ Mail<br>☐ In-Person Pick up (Name:_____) |

## PART F: REVIEW AND APPROVAL

I understand that the information to be released may include reference to sensitive information related to mental and behavioral health, genetic testing, HIV/AIDS or other communicable diseases, and drug or alcohol abuse. I specifically approve the release of the following information that has been marked as sensitive and/or restricted (check all that apply):

☐ Mental and Behavioral Health ☐ Substance Use Disorder ☐ Genetic Testing

I understand that I may revoke this Authorization in writing at any time, except to the extent that action has already been taken in response to the Authorization. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law. I understand that I may refuse to sign this Authorization. If I do not sign this Authorization, Duke Health will continue to provide treatment and seek payment for services provided. Duke Health may charge a fee for providing the information specified above.

**This Authorization will automatically expire one year from the date signed below unless revoked or another date or event is written here:** _____.

| | | |
|---|---|---|
| Signature | Printed Name | Date |
| Witness Signature | ID # | Date |

## PART G: REPRESENTATIVE (complete if signed by personal or authorized representative)

| | | |
|---|---|---|
| Representative Full Name (please print) | Relationship to Patient | Phone Number |

**If you are not the patient or the parent of a minor patient, you MUST attach documentation of your authority to act on behalf of the patient (Power of Attorney, Court Order, Legal Guardian Documentation, Executor/Administrator Documentation)**

SEND COMPLETED FORM TO: ROI-requestor3@dm.duke.edu; Fax: 919-620-5165 OR
Duke University Hospital - HIM P.O. Box 3016 Durham, NC 27710; For Questions Call: 919-684-1700