M20UP-045
Rev. 3/9/20

DukeHealth

Request for External Records

Place Patient Label Here

☐ Duke University Hospital ☐ Duke Raleigh Hospital ☐ Duke Regional Hospital
☐ Davis Ambulatory Surgical Center ☐ Other ______________________________

THIS FORM SHOULD **ONLY** BE USED WHEN REQUESTING HEALTH INFORMATION FROM AN OUTSIDE HEALTH CARE PROVIDER FOR CONTINUITY OF CARE

REQUEST FOR EXTERNAL RECORDS

PART A: PATIENT INFORMATION		
Patient Name:	Phone:	Email:
Address:		
Date of Birth:	SS# (last 4 digits):	Duke Health Medical Record #:

PART B: REQUESTING INFORMATION FROM		
Outside Health Care Provider		
Name:______________________	Phone:______________	Email:______________
Address:______________________		Fax:______________

PART C: SENDING INFORMATION TO		
Duke Health Provider		
Name:______________________	Phone:______________	Email:______________
Address:______________________		Fax:______________

PART D: 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 ☐ History and Physical ☐ Consultation Report ☐ Operative Report ☐ Laboratory Reports ☐ Pathology Reports	☐ Radiology Reports ☐ Radiology Images ☐ Physical/Occupational Therapy ☐ Immunization Record ☐ Emergency Department Record	☐ Clinic Visit (Specify Provider/Clinic) ______________ ☐ Other (please specify) ________ ______________	☐ Entire Record ☐ Billing Records

Treatment Date(s):
☐ From______________to______________(please be specific) ☐ All Treatment Dates

PART E: REVIEW AND APPROVAL

The purpose of this release is for continuity of care, unless otherwise noted:______________________

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

This Form will automatically expire one year from the date signed below unless revoked or another date or event is written here: ______________________

Patient or Duke Health Representative Signature	Printed Name	Date

PART F: 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, parent of a minor patient, or a Duke Health representative you MUST attach documentation showing your authority to act on behalf of the patient (Power of Attorney, Court Order, Legal Guardian Documentation, Executor/Administrator Documentation)