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 ☐ 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 Location:

☐ All Duke Health Enterprise Entities	☐ Duke University Hospital ☐ Duke Raleigh Hospital	☐ Duke Regional Hospital ☐ Duke Clinic (specify provider / location) _____

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 ☐ CD ☐ Thumb drive (flash drive) ☐ Fax	☐ Oral Communication	☐ Electronic (MyChart, encrypted email) ☐ Mail ☐ 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