



DukeHealth

AUTHORIZATION FOR RELEASE OF INFORMATION



Place Patient Label Here

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:

<input type="checkbox"/> Abstract/Summary (Discharge Summary, Operative/Procedure Notes, Pathology, Laboratory, ED Notes, Clinic Visits, Consults)	<input type="checkbox"/> Discharge Summary <input type="checkbox"/> History and Physical <input type="checkbox"/> Consultation Report <input type="checkbox"/> Operative Report <input type="checkbox"/> Laboratory Reports <input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Radiology Reports <input type="checkbox"/> Radiology Images <input type="checkbox"/> Physical/Occupational Therapy <input type="checkbox"/> Immunization Record <input type="checkbox"/> Emergency Department Record	<input type="checkbox"/> Clinic Visit (Specify Provider/Clinic) _____ <input type="checkbox"/> Other (please specify) _____	<input type="checkbox"/> Entire Record <input type="checkbox"/> Billing Records
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Treatment Location:

<input type="checkbox"/> All Duke Health Enterprise Entities	<input type="checkbox"/> Duke University Hospital <input type="checkbox"/> Duke Raleigh Hospital	<input type="checkbox"/> Duke Regional Hospital <input type="checkbox"/> Duke Clinic (specify provider / location) _____
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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) <input type="checkbox"/> MyChart <input type="checkbox"/> Encrypted Email <input type="checkbox"/> Paper <input type="checkbox"/> CD <input type="checkbox"/> Thumb drive (flash drive) <input type="checkbox"/> Fax	Other <input type="checkbox"/> Oral Communication	Delivery Method (select only one) <input type="checkbox"/> Electronic (MyChart, encrypted email) <input type="checkbox"/> Mail <input type="checkbox"/> In-Person Pick up (Name: _____)
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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
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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)