AUTHORIZATION TO Use or Disclose Protected Health Information (PHI)

Patient's Name			*Verification of Identity* ☐ *Driver's License/State ID* ☐ *Personally known* ☐ *Other:* _______________
Patient's Address *City* *State* *Zip*			*Date of Birth*
Phone #		*Last 4 of SSN (Voluntary)*	*Medical Record #*
Complete the following only if the person signing this authorization is not the patient:	*Name of Representative*	*Relationship to Patient*	*Verification of Identity* ☐ *Driver's License/State ID* ☐ *Personally known* ☐ *Other:* _______________
	Address and phone number		*Verification of Authority*

I authorize the release of PHI (i.e., medical records) FROM the UNC Health Care doctor, office, facility or other health care provider below:		
Name of Person, Organization or Facility		
Street Address	*City State, Zip*	*Phone #*

PERSON OR COMPANY WHO WILL RECEIVE INFORMATION:			
Name of Person, Organization, or Facility			
Street Address	*City State, Zip*	*Phone#*	*Fax#*

INFORMATION THAT CAN BE RELEASED: If specific Dates only, list dates: ____

Records To Be Released	☐ Operative/Procedure Notes	☐ Progress Notes (inpatient)	**I further authorize the release of the following information which may be included in my PHI:**
☐ Clinic Notes (outpatient)	☐ Provider Orders	☐ Patient Billing Records	☐ Mental Health/Psychiatric Treatment
☐ Emergency Dept. Notes	☐ Radiology Reports	☐ Film/CD (Imaging Support)	☐ Alcohol or Substance Abuse Treatment
☐ Urgent Care Center Notes	☐ Consultations	☐ All My Medical Records	☐ STD/HIV/AIDS Treatment(s) or Test(s)
☐ History and Physical	☐ Laboratory Reports		☐ Genetic Testing
☐ Discharge Summary	☐ Other (describe in detail):		

Purpose of the Request ☐ Billing or Insurance ☐ Treatment/Continued Patient Care ☐ Personal ☐ Other: _____________________________

Delivery Method

☐ Mail to address listed above
☐ Review or pick up in HIM Department
☐ Fax to # listed above (Health care providers only, no personal faxes)
☐ Other: _______________________________

☐ Receive electronically via email
Email: ___________________________
(*check one*)
☐ Unsecure/unencrypted*
☐ Secure/ encrypted *(may be size limitations)*
*communication by unencrypted email presents a risk that personally identifiable information contained in the email, may be intercepted by unauthorized third parties

☐ Release to web portal via MyUNCChart in electronic format.
(Once logged into your account, access to your records will require entering 4-digit birth year; access will only be available for 30 days; you may print and/or save a copy for personal use)

My signature on this Authorization indicates that I am giving permission for the use or disclosure of the PHI described above. I understand the following:

- I hereby release UNC Health Care System and its affiliates and employees from any and all liability that may arise from the release of this information.
- I have the right to revoke this Authorization at any time if I do so in writing and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this Authorization.
- I may refuse to sign this Authorization, and I cannot be denied or refused treatment if I refuse to sign.
- My refusal to sign this Authorization will not affect my treatment, payment, enrollment or eligibility for benefits or the quality of care I receive.
- Once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy laws and could be re-disclosed by the person or agency that receives it.
- This Authorization shall remain in effect until the sooner of **one (1) year** from the date I sign it or upon my written revocation.
- I am aware that I may be charged a fee for this request as allowed by law. Fees are waived when PHI is released to another provider for treatment purposes.

Signature of Patient or Legal Representative	*Date*

Complete all parts of the form, print out and sign and date. - Mail form to HIM, Nash UNC Health Care, 2460 Curtis Ellis Drive, Rocky Mount, NC 27804].