

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Request Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information requested by: 🞏 Patient 🞏 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information requested:**
🞏 All chart/progress notes 🞏 Radiology only 🞏 Immunization records only
🞏 Lab work only 🞏 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of this Authorization:**🞏 Further Medical Care 🞏 Changing Physicians 🞏 Legal action
🞏 Personal 🞏 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Information to be released TO:** |
| Name of Facility: |
| Address: |
| Phone: |

|  |
| --- |
| **Information to be released FROM:** |
| Name of Facility: |
| Address: |
| Phone: |

This authorization shall expire on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and is needed for the period beginning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ and ending on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
I hereby give the releasing facility permission to disclose my health information. I certify that this request is made voluntarily and that I may revoke this authorization at any time, except to the extent that action has already been taken. I agree that UNC is not responsible for the misuse or cannot guarantee the confidentiality of medical information once it is released to another party. I hereby release UNC from any liability, which may result from furnishing the information requested as authorized in this release.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INTERNAL USE ONLY – Records Released on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Released By: \_\_\_\_\_\_\_\_\_\_