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: _____