

Instructions for Completing the Authorization for Release of Information Form

If you have any questions, please call the HIM Department at 919-684-1700.

Please read the following for help with completing the Authorization.

PART A: PATIENT INFORMATION

This section applies to the person whose information or records are being requested.

- Write the patient's full name, phone number, e-mail address, and mailing address. If the patient has a preferred name, include in this section. Include other identifiers such as the patient's date of birth, last four digits of social security number, and medical record number if known.

PART B: PERSON OR COMPANY WHO WILL RECEIVE INFORMATION

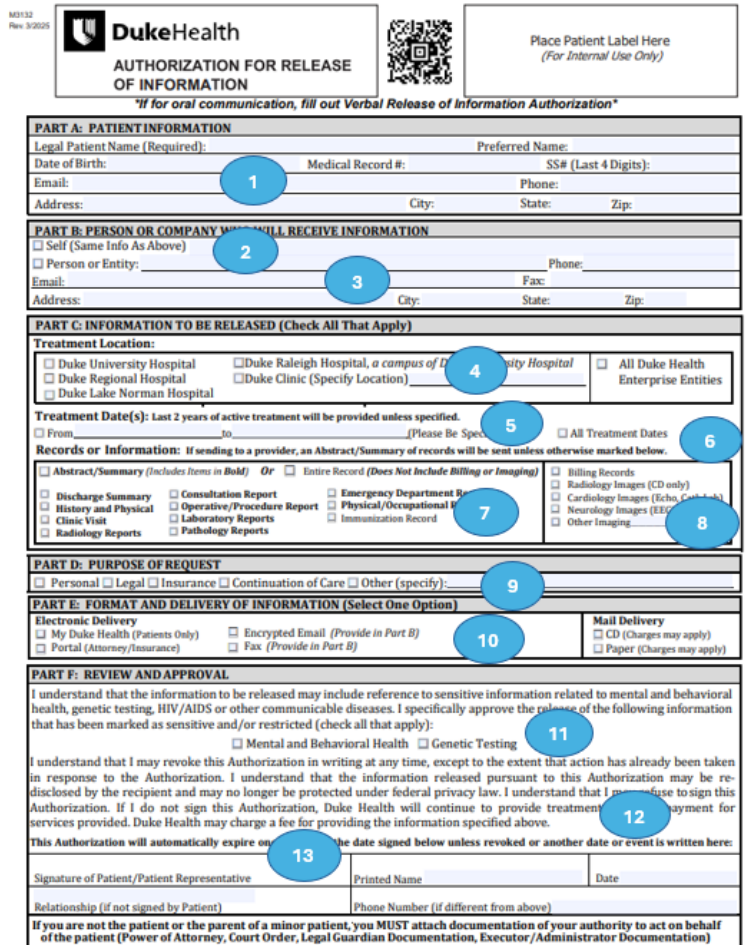
Complete this section so we know where to send the information or records.

- If you are the patient and are requesting the record to be sent to you, select "Self."
- If the records should be sent to another person or company, print the full name and address of the person or company where we should send the information or records. You must be specific. General terms like "my son" or "my daughter" does not provide sufficient information to release records.

PART C: INFORMATION THAT CAN BE RELEASED

This section tells us what information or records you would like us to release.

- Check the box where the treatment occurred. If you are unsure, or want records from all treatment locations, check "All Duke Health Enterprise Entities."
 - Note, if you select one of the hospital locations, we will also release your records from the clinics located at that hospital.
 - If you are requesting records from a specific clinic, please specify the clinic or provider.
- Indicate the treatment dates to be released. If no dates are selected, the last 2 years of active treatment will be provided.
- If sending to a provider, an Abstract/Summary will be sent unless otherwise marked.
- For an Abstract/Summary of your records, select the box "Abstract/Summary." These will include the following records:
 - Discharge Summary** - A summary at the conclusion of a hospital stay.
 - History & Physical** - Hospital admission report of past medical history provided by the patient or patient representative and the provider's documentation of the initial physical examination of the patient.
 - Clinic Visits** - Outpatient doctor or clinical notes from a clinical office setting including test results from any diagnostic tests ordered and completed.
 - Consultation Report** - Report from a hospital stay with consulting physician when the attending provider asks another provider to examine the patient's specific medical problem.



M3132 Rev. 3/2025

DukeHealth
AUTHORIZATION FOR RELEASE OF INFORMATION

Place Patient Label Here (For Internal Use Only)

"If for oral communication, fill out Verbal Release of Information Authorization"

PART A: PATIENT INFORMATION
 Legal Patient Name (Required): _____ Preferred Name: _____
 Date of Birth: _____ Medical Record #: _____ SS# (Last 4 Digits): _____
 Email: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____

PART B: PERSON OR COMPANY WHO WILL RECEIVE INFORMATION
 Self (Same Info As Above) _____ Phone: _____
 Person or Entity: _____ Fax: _____
 Address: _____ City: _____ State: _____ Zip: _____

PART C: INFORMATION TO BE RELEASED (Check All That Apply)
Treatment Location:
 Duke University Hospital Duke Raleigh Hospital, a campus of Duke University Hospital All Duke Health Enterprise Entities
 Duke Regional Hospital Duke Clinic (Specify Location) _____
 Duke Lake Norman Hospital _____

Treatment Date(s): Last 2 years of active treatment will be provided unless specified.
 From _____ to _____ (Please Be Specific) All Treatment Dates

Records or Information: If sending to a provider, an Abstract/Summary of records will be sent unless otherwise marked below.

Abstract/Summary (Includes Items in Bold) **Or** Entire Record (Does Not Include Billing or Imaging) Billing Records
 Discharge Summary Consultation Report Emergency Department Report Radiology Images (CD only)
 History and Physical Operative/Procedure Report Physical/Occupational Report Cardiology Images (Echo, Cath, etc.)
 Clinic Visit Laboratory Reports Immunization Record Neurology Images (EEG, etc.)
 Radiology Reports Pathology Reports Other Imaging _____

PART D: PURPOSE OF REQUEST
 Personal Legal Insurance Continuation of Care Other (specify): _____

PART E: FORMAT AND DELIVERY OF INFORMATION (Select One Option)
 Electronic Delivery Encrypted Email (Provide in Part B) Mail Delivery
 My Duke Health (Patients Only) Fax (Provide in Part B) CD (Charges may apply)
 Portal (Attorney/Insurance) Paper (Charges may apply)

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. 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 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 released pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy law. I understand that I must pay for services provided. Duke Health may charge a fee for providing the information specified above.

This Authorization will automatically expire on _____ the date signed below unless revoked or another date or event is written here:

Signature of Patient/Patient Representative _____ Printed Name _____ Date _____
 Relationship (if not signed by Patient) _____ Phone Number (if different from above) _____

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 ONE OF THE FOLLOWING:
 Fax: 919-620-5165 - ROI-requestor@idm.duke.edu; For Questions Call: 919-684-1700;
 Duke University Hospital - HIM, DUMC Box 3016, Durham, NC 27710

- e. **Operative/Procedure Notes** -A report by a surgeon or other physician(s) who performed/participated in a surgery or procedure, with details of the findings, the procedure used, the specimens removed, the preoperative and postoperative diagnoses, and names of the primary performing surgeon and any assistants.
 - f. **Laboratory** - A procedure in which a health care provider takes a sample of the patient's blood,urine, other bodily fluid, or body tissue to obtain information about the patient's health.
 - g. **Pathology** - Report that contains the diagnosis determined by examining cells and tissues under a microscope.
 - h. **Radiology Reports** - Reports of radiological or computerized imaging related to testing performed to diagnose a patient's condition such as broken or displaced bones, foreign objects or masses, abnormal functions of organs, etc.
 - i. **Physical/Therapy Occupational Record** - Documented notes for the assessment and treatment of physical, occupational or speech communication problems or disorders.
 - j. **Emergency Department Record** - Documented notes by doctors or other clinicians regarding treatment received in the emergency department including test results from any diagnostic tests ordered and completed.
 - k. If you need specific information, select specific individual reports here.
8. For all your medical records, except billing and various images, select "Entire Record." You must specifically select "Billing Records" and/or select the specific images to receive those records.

PART D: PURPOSE OF REQUEST

9. Check the box that provides the reason you want the information or records.

PART E: FORMAT AND DELIVERY OF INFORMATION

This section tells us how to send the information or records.

10. If you want an electronic or paper copy of the records, check a box in one of the columns that applies.

Electronic Delivery:

- a. *MyChart – Depending on size, records can be uploaded directly to your MyChart account.
 - i. Patient must have an active MyChart Account
 - ii. Minor Children under age 12 – will be released to parents/guardians with MyChart access.
 - iii. Children Ages 12-17 – Unable to release records to MyChart unless the teen has an active Teen Account and is requesting their own records. Alternative means of delivery will be requested to release records to parents/guardians.
- b. Portal – Use of vendor portal by patients, attorneys, insurance companies, and other 3rd. parties.
- c. Encrypted Email –A PDF copy of the records can be securely emailed to you.
- d. Fax
- e. Mail:
 - i. CD – A PDF copy of the records can be placed on an encrypted CD and mailed to you.
 - ii. Paper

***Depending on size of file, we may contact you to select a different format of delivery.**

PART F: REVIEW AND APPROVAL

11. Your records may include reference to sensitive types of information. In addition, some records have been marked as sensitive by Duke Health and will not be released without your approval. If you wish to approve the release of information that has been marked as sensitive, check the box(es) that apply to you.
12. If you would like for the Authorization to expire on a specific date or following a specific event, please write the date or event at the bottom of Part F. If no date or event is provided, the Authorization will automatically expire one year from the signature date in Part F.

13. Signature of Patient/Patient Representative:

a. If you are the patient:

- i. **Sign your name, print your name, and put the date on the form.** Your name and signature must match the information in Part A.
- ii. If you are the patient's representative, **print your full name, write your relationship to the patient, and write your phone number.**
- iii. Parents of minors between ages 0-17 and listed on the record do not require additional documentation unless other documentation on file expresses loss of legal parental rights.
- iv. If you are requesting records for a minor between ages 0-17 and you are not the parent listed on the record, you must also provide us with a copy of the legal document showing us that you are authorized to sign the Authorization and include the document when submitting this form.
- v. If you are the personal representative of an adult, you must also provide us with a copy of the legal document showing us that you are authorized to sign the Authorization and include the document when submitting this form.

Some examples of legal documents may include:

- **Legal Guardianship** – This is established by a court who will appoint someone to care for another person such as a minor 0-17 years old or an incapacitated adult.
 - **Health Care or General Power of Attorney** – This document gives someone you trust the legal power to act on your behalf and to make health care or financial decisions for you. Often, the Health Care Power of Attorney is contingent on the occurrence of an event (such as the incapacity of the patient). Make sure to provide documents that show that the triggering event has occurred.
 - **Executor/Executrix of Estate** – This type of document would be used when an individual over the age of 17 who is being represented has died, and the court system has designated the individual as the administrator of the estate.
 - **Next of Kin** – Where an individual has died without a will, you may submit a “**DUHS Affidavit of Surviving Spouse or Next of Kin**,” to establish that the patient died intestacy (without a will) and that you are the nearest next of kin.
 - **Next of Kin Order:**
 - Surviving Spouse
 - Adult Children – in absence of spouse listed above
 - Parent(s) – in absence of spouse or adult children
 - Siblings(s) - in absence of all others listed above
 - **Supporting documentation is required, such as:**
 - Death Certificate
 - Marriage License
 - Birth Certificate
 - Obituary
- *For anyone other than a parent/guardian of a minor patient or a spouse listed on the record, please provide as much information as possible to support next of kinship. Additional information may be requested as needed to determine authority to sign the Authorization.

Mail, E-mail, or Fax a copy of the Authorization to the following address:

Mail:

Duke University Hospital HIM
P.O. Box 3016 Durham, NC 27710

E-mail: ROI-requestor3@dm.duke.edu

Fax: 919-620-5165

Call: 919-684-1700