M20UP-045
Rev. 6/24

DukeHealth

Request for External Records

Place Patient Label Here

- ☐ Duke University Hospital
- ☐ Duke Raleigh Hospital, *a campus of Duke University Hospital*
- ☐ Duke Eye Center, *a department of Duke University Hospital*
- ☐ Raleigh Ambulatory Surgery Center, *a campus of Duke University Hospital*
- ☐ Duke Ambulatory Surgery Center, *a campus of Duke University Hospital*
- ☐ Duke Regional Hospital
- ☐ Duke Health Integrated Practice
- ☐ Duke Primary Care
- ☐ Arringdon Ambulatory Surgery Center
- ☐ Davis Ambulatory Surgery Center
- ☐ Other (Please specify): _____

THIS FORM SHOULD **ONLY** BE USED WHEN REQUESTING HEALTH INFORMATION FROM AN OUTSIDE HEALTH CARE PROVIDER FOR CONTINUITY OF CARE

REQUEST FOR EXTERNAL RECORDS

PART A: PATIENT INFORMATION

Patient Name: Phone: Email:

Address:

Date of Birth: SS# (last 4 digits): Duke Health Medical Record #:

PART B: REQUESTING INFORMATION FROM

Outside Health Care Provider

Name:_____ Phone:_____ Email:_____

Address:_____ Fax:_____

PART C: SENDING INFORMATION TO

Duke Health Provider

Name:_____ Phone:_____ Email:_____

Address:_____ Fax:_____

PART D: INFORMATION TO BE RELEASED (check all that apply)

Records or Information:

☐ Abstract/Summary (Discharge Summary, Operative/Procedure Notes, Pathology, Laboratory, ED Notes, Clinic Visits, Consults)	☐ Discharge Summary ☐ History and Physical ☐ Consultation Report ☐ Operative Report ☐ Laboratory Reports ☐ Pathology Reports	☐ Radiology Reports ☐ Radiology Images ☐ Physical/Occupational Therapy ☐ Immunization Record ☐ Emergency Department Record	☐ Clinic Visit (Specify Provider/Clinic) _____ ☐ Other (please specify) _____	☐ Entire Record ☐ Billing Records

Treatment Date(s):
☐ From_____ to_____ (please be specific) ☐ All Treatment Dates

PART E: REVIEW AND APPROVAL

The purpose of this release is for continuity of care, unless otherwise noted:_____

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

This Form will automatically expire one year from the date signed below unless revoked or another date or event is written here: _____

Patient or Duke Health Representative Signature	Printed Name	Date

PART F: REPRESENTATIVE (complete if signed by personal or authorized representative)

Representative Full Name (please print)	Relationship to Patient	Phone Number

If you are not the patient, parent of a minor patient, or a Duke Health representative you MUST attach documentation showing your authority to act on behalf of the patient (Power of Attorney, Court Order, Legal Guardian Documentation, Executor/Administrator Documentation)