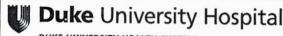
M3132 Rev. 7/10



DUKE UNIVERSITY HEALTH SYSTEM

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION AT DUKE UNIVERSITY MEDICAL CENTER\*

Patient Name:	
Medical Record Number:	
Date of Birth:	
Phone Number:	

If mailing this form please send to: Duke University Hospital

Health Information Management Department

Attn: Medical Information Release Unit

P.O. Box 3016 Durham, N.C. 27710

I authorize and request Duke University\*, Duke University Hospital\* (a component of the Duke University Health System), and the Private Diagnostic Clinic, PLLC\* to release the following noted protected health information from the medical records of the Patient listed above to: (Person/Physician/Entity TO RECEIVE records-please be specific) ☐ To be mailed to: \_\_\_\_\_ PLEASE SCAN TO PATIENT'S CHART By electronic access to medical and claims information. ☐ Through oral communication with healthcare providers regarding treatment, care or payment. The specific information for the following dates of service: INFORMATION TO BE DISCLOSED (check the appropriate boxes and include other information where indicated): ☐ Summary Health Information (Includes Discharge Summary, History and Physical, Radiology, Pathology, Laboratory, and Dictated notes) History and Physical (e.g., Doctor Visit) □ Laboratory Reports ☐ Discharge Summary □ Radiology Reports Operative Report ☐ Emergency Department Reports Immunization Records ☐ Physical Therapy/Occupational Therapy Notes ☐ Entire Record ☐ Patient Discharge Instructions PROTECTED HEALTH INFORMATION □ Other: ☐ Information contained in the Patient's medical record related to psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment to date. ☐ Information contained in the Patient's medical record related to treatment for alcohol and/or drug abuse. THE INFORMATION TO BE DISCLOSED WILL BE USED FOR THE FOLLOWING PURPOSE: ☐ Fax to MD for Continuing Care ☐ Insurance processing ☐ Sharing with other health care providers as needed Personal use Legal reasons **DUKE'S PATIENT ASSISTANCE PROGRAM** 



This Authorization shall cover actions by and for Duke University, Duke University Health System, and the Private Diagnostic Clinic, PLLC, and all of their respective employees, workforce, and business associates. This Authorization may be revoked at any time, provided the revocation is a properly executed written document and delivered to the Health Information Management Department (see address above). Such revocation shall not affect disclosures prior to the revocation to the extent that this Authorization was relied upon for such disclosures made prior to the revocation. I understand that once the information is disclosed, it may be re-disclosed by the recipient and federal and/or state privacy laws may not protect the re-disclosure. I understand authorizing the disclosure of information identified above is voluntary, and this Authorization is not intended to alter the patient's ability to receive medical care from any health care provider.

This authorization will expire on the following date or event:

If I fall to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

Signature of Patient\*\* or Legal Representative\*\*

Date Time

Signature of Witness

\*\*If the Patient is under 18 years of age, unless the Patient is an emancipated minor, this Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the minor-Patient's behalf. By signing this form for someone else, you as the parent, guardian, a party acting in loco parentis, or legal representative warrant that you have the legal authority to act on the Patient's behalf and that you are not prohibited by Court Order from having access to the requested medical records.

\* Several components and sites of Duke University, the Duke University Health System, and the Private Diagnostic Clinic, PLLC maintain <u>separate</u> medical records (e.g., student health, primary care, community PDC practices, etc.) that are <u>not</u> electronically linked and therefore <u>not</u> covered by this Authorization. If applicable, please contact those components / sites for additional medical records.