



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

Patient Name:	Phone:	Email:
Address:		
Date of Birth:	SS# (last 4 digits):	Medical Record #:

PART B: PERSON OR COMPANY WHO WILL RECEIVE INFORMATION

Self (same info as above)

Person or Entity: _____ Phone: _____ Email: _____

Address: _____ Fax: _____

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

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.

<input type="checkbox"/> Abstract/Summary (Discharge Summary, History & Physical, Consults, Operative/Procedure Notes, Laboratory, Pathology, Radiology Reports, PT/OT, ED, Clinic Visits)	Or	<input type="checkbox"/> Entire Record
Or, Select Specific Individual Reports To Include:		
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Consultation Report	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Operative/Procedure Report	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Clinic Visit	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Immunization Record
	<input type="checkbox"/> Emergency Department Record	<input type="checkbox"/> Radiology Images
	<input type="checkbox"/> Physical/Occupational Record	<input type="checkbox"/> Billing Records

Treatment Location:

<input type="checkbox"/> All Duke Health Enterprise Entities	<input type="checkbox"/> Duke University Hospital	<input type="checkbox"/> Duke Regional Hospital
	<input type="checkbox"/> Duke Raleigh Hospital	<input type="checkbox"/> Duke Clinic (specify location) _____

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 <input type="checkbox"/> MyChart (patients only) <input type="checkbox"/> Encrypted Email <input type="checkbox"/> Portal (attorney/insurance) <input type="checkbox"/> Fax	Mail Delivery <input type="checkbox"/> CD <input type="checkbox"/> Thumbdrive <input type="checkbox"/> Paper	In-Person Pick up Name: _____ <input type="checkbox"/> CD <input type="checkbox"/> Thumbdrive <input type="checkbox"/> Paper
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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 disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal privacy law. I understand that I may refuse to sign this Authorization. If I do not sign this Authorization, Duke Health will continue to provide treatment and seek payment for services provided. Duke Health may charge a fee for providing the information specified above.

This Authorization will automatically expire one year from 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)	

PART G: WITNESS (Optional – See Instructions for Details)

Witness	Patient or Personal Representative ID type presented
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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)