Johnston Health
509 North Brightleaf Blvd.
Health Information Management
Smithfield, North Carolina 27577
919-938-7705; Fax 919-934-9266

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize:

	UNC Health Care System	OR		Other facility:

To use or disclose to:

Name of Facility:		Attention:	
Address	City	State	Zip
Phone:	Fax:	Email:	

The protected health information of:

Patient Name:		Date of Birth:	SS# (last 4):
Address	City	State	Zip
Phone:		Medical Record Number	

Dates of Service: _____

Put a CHECKMARK next to the specific documents that apply to your request:

	Clinic notes (outpatient)		Operative / Procedure notes		Progress Notes (inpatient)		
	Emergency Dept. notes		Providers Orders		Radiology reports		
	Urgent Care Center notes		Nursing notes		Abstract		
	History and Physical		Consultations		Film / CD (Imaging support)		
	Discharge Summary		Laboratory reports				
Other (describe)							

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (includíng records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable díseases, and genetic testing. This authorization does not include permission to release psychotherapy notes (defíned as records from private, joint, group, or family counseling sessions that are separated from the rest of the patient's medícal record). Release of psychotherapy notes requires a separate authorization.

Put a CHECKMARK next to the purpose of the request:

	Personal Use		Continued Patient Care		Other:

If you desire to request records for your Attorney/Legal services, Insurance Company, etc., that organization is responsible for submitting a request on your behalf.

Put a <u>CHECKMARK next</u> to how you would like to receive your request:

	Mail to address listed above
	Review in Release department (HIM)

	Fax to # listed above **(Health care providers only; no personal faxes)**
	Review rernotely **(employecs offly with EHR Access)**
	Release to MyUNCChart* **(Will require entering 4-digit birth year)****

	Pick Up Release in Dept (HIM) *Fee will be applied.
	Other. Specify:

***Releases to MyUNC Chart must be processed by HIM**
****Access via MyUNC Chart will on1y be available for 30 days; although you may print and/or save a copy for your personal use.**

I UNDERSTAND THAT:

• I may revoke this Authorization at any time:
- o The revocation will not apply to information that has already been released in response to this Authorization.
- o I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the Health Information Management Department.

I may refuse to sign, this Authorization:
- o My treatment, payment, enrollment in a health plan, or eligibility for benefits can not be conditioned upon my authorization of this disclosure.
- o A fee may be charged for providing the protected health information. Please contact Scanstat to obtain fee and rate information at 919-938-7705.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. lt is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ lf I fail to specify an expiration date or event or condition, this authorization will expire automatically in ninety (90) days from the date of signature.

I have read and understand the information in this Authorization form.

Signature of Patient:		
Printed Name:	Date:	Time:

Or

Signature of Authorized Representative:		
Printed Name:	Date:	Time:

Please explain Representative's authority to act on the behalf of patient:

Identification as well as Legal documnet will be required for review at pickup (If mailing request, copies of listed documentation must be mailed with request)

OFFICE USE ONLY

PROCESSED DATE: _____ ☐ ID Checked
PROCESSED BY: _____
TOTAL PAGES: _____
Additional NOTES:

STAMPS / ADDITIONAL NOTES: