M3132
Rev. 1/22

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.

☐ **Abstract/Summary** (*Discharge Summary, History & Physical, Consults, Operative/Procedure Notes, Laboratory, Pathology, Radiology Reports, PT/OT, ED, Clinic Visits*) ***Or*** ☐ **Entire Record**

***Or*, Select Specific Individual Reports To Include:**

☐ Discharge Summary	☐ Consultation Report	☐ Radiology Reports	☐ Emergency Department Record	☐ Radiology Images
☐ History and Physical	☐ Operative/Procedure Report	☐ Pathology Reports	☐ Physical/Occupational Record	☐ Billing Records
☐ Clinic Visit	☐ Laboratory Reports	☐ Immunization Record		

Treatment Location:

☐ All Duke Health Enterprise Entities	☐ Duke University Hospital ☐ Duke Regional Hospital ☐ Duke Raleigh Hospital ☐ 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		**Mail Delivery**	**In-Person Pick up**
☐ MyChart (patients only)	☐ Encrypted Email	☐ CD	Name:_____
☐ Portal (attorney/insurance)	☐ Fax	☐ Thumbdrive	☐ CD ☐ Thumbdrive ☐ Paper
		☐ Paper	

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, 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

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

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: ROI-requestor3@dm.duke.edu; Fax: 919-620-5165
Duke University Hospital - HIM, DUMC Box 3016, Durham, NC 27710; For Questions Call: 919-684-1700