AUNC Associated Urologists of North Carolina, PA

Friendly, affordable urology care...when you need it.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

Patient Name: _____ Maiden Name: _____ SS#: _____

Date of Birth: _____ Home Phone: _____ Cell/Work: _____

Address: _____ City/State/Zip: _____

- ☐ **I hereby authorize records FROM:**

  Name: _____ Phone #: _____ Fax #: _____

  Address: _____ City/State/Zip: _____

  To be released TO:

  Name: _____ Phone #: _____ Fax #: _____

  Address: _____ City/State/Zip: _____

- ☐ **For the Purpose of:** _____

  ____ Litigation ____Insurance ____ Self/Personal Copy ____Continuity of Care

  ____ Disability ____ Work Comp ____ Other ____ Transfer of Care (Permanently Leaving)

- ☐ **DATE RANGE:** _____

  ____ Physician Office Notes ____ Immunizations ____Operative/Procedure Reports

  ____ Cardiology/EKG Reports ____ Lab/Path Reports ____ Radiology/X-Ray/MRI

  ____ Minimum Necessary ____ Other:_____

- ☐ **I request that the medical records be:** *Please check appropriate box.*
  - Mailed directly to the facility/office/company/person specified above.
  - Faxed to the follow number. Fax Number: _____
  - Email my protected health information. Email: _____
  - I authorize AUNC to give **verbal information ONLY** regarding my treatment to the above person/s.

____ I do ____ I do **NOT** authorize release of information related to AIDS or HIV infection, psychological assessment, and treatment for alcohol and/or drug abuse.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire one year from the above date unless I specify an expiration date: _____

PLEASE READ Fee Information: AUNC reserves the right to charge as necessary for medical records request.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

(Date) (Signature of Patient/Parent/Guardian/Authorized Representative)