Authorization for Release of Medical Records to the Duke Student Health Center

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

I authorize and request that: _____
(Person/Physician/Entity ***to release*** records)

- ❒ Mail to the Duke Student Health Center, DUMC Box 2899, Durham, NC 27710.
- ❒ Fax to the Duke Student Health Center, Fax: 919-681-2874. Phone: 919-681-WELL.
- ❒ 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
(History and Physical, Radiology, Pathology, Laboratory, and Dictated notes)
- ❒ History and Physical (e.g., Doctor Visit)
- ❒ Laboratory Reports
- ❒ Radiology Reports
- ❒ Immunization Records
- ❒ Physical Therapy Notes
- ❒ Comprehensive Record
- ❒ 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:

- ❒ Sharing with other health care providers as needed
- ❒ Insurance processing
- ❒ Legal reasons
- ❒ Personal use
- ❒ Other:_____

This Authorization shall cover actions by and for the Duke Student Health Center, and all of its 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 Duke Student Health Center. 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 fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

_____ _____ _____
Date Signature of Patient* or Legal Representative* 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.