**RELEASE OF MEDICAL INFORMATION AUTHORIZATION**

I AUTHORIZE UNC HEALTH CARE SYSTEM TO DISCLOSE TO:

|  |  |  |
| --- | --- | --- |
| Name of Person or Facility: | | |
| 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: | UNC Medical Record # | |

The specific information to be disclosed is:

* Completed referral form with physician signature (see reverse)
* Brief history and physical
* Discharge summary
* 12 lead EKG
* Lipid profile
* Fasting glucose
* Graded exercise test report and EKG tracing

I UNDERSTAND:

* THE PURPOSE OF THIS REQUEST IS TO SUPPORT CONTINUED PATIENT CARE IN CARDIAC REHABILITATION.
* I MAY REFUSE TO SIGN THIS AUTHORIZATION AND THAT MY TREATMENT, PAYMENT, ENROLLMENT IN A HEALTH PLAN, OR ELIGIBILITY FOR BENEFITS CANNOT BE CONDITIONED UPON MY AUTHORIZATION OF THIS DISCLOSURE.
* I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY PROVIDING A WRITTEN NOTICE OF AUTHORIZATION TO UNC HOSPITALS’ MEDICAL INFORMATION MANAGEMENT DEPARTMENT. THE REVOCATION WILL NOT APPLY TO INFORMATION THAT ALREADY HAS BEEN RELEASED IN RELIANCE ON THIS AUTHORIZATION.
* UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF SIGNATURE.
* INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY A RECIPIENT OF SUCH INFORMATION. IT IS POSSIBLE THAT, ONCE DISCLOSED, THE PRIVACY OF THE INFORMATION MAY NO LONGER BE PROTECTED UNDER FEDERAL PRIVACY LAWS.

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS AUTHORIZATION FORM.

SIGNATURE OF PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OR

SIGNATURE OF

AUTHORIZED REPRESENTATIVE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXPLAIN REPRESENTATIVE’S AUTHORITY TO ACT ON BEHALF OF THE PATIENT:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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