



UNC
HOSPITALS

Para rayos x de radiología enviar a:
For Radiology Films please send:
ATTN: FILM MANAGEMENT
(919) 966-3280, Fax (919) 966-4990

Para todos los otros expedientes médicos enviar a:
For all other record requests please send:
ATTN: RELEASE OF MEDICAL INFORMATION
(919) 966-2336, Fax (919) 966-6295

UNC Health Care System

101 Manning Drive, Chapel Hill, NC 27514

FORMULARIO DE AUTORIZACIÓN PARA LA DIVULGACIÓN DE INFORMACIÓN MÉDICA
RELEASE OF MEDICAL INFORMATION AUTHORIZATION FORM – MIM #710-S

Yo autorizo
I authorize:

UNC Health Care System

O/OR

Otro/Other:

A usar o divulgar a:

To use or disclose to:

Nombre/Name

Dirección/Address

Ciudad/City

Estado/State

Código Postal/Zip Code

la información médica protegida de/the protected health information of

Nombre del paciente/Patient Name: _____ Fecha de nacimiento/Date of Birth: ____/____/____

Dirección/Address: _____ Ciudad/City: _____ Estado/State: ____ Código Postal/Zip Code _____

Teléfono/Tel: (____) _____ No. de Seguro Social/SSN (sólo los últimos 4 dígitos/last 4 digits only): _____

No. de expediente médico de UNC HCS/ UNC HCS Medical Record # _____

FECHAS DEL TRATAMIENTO/TREATMENT DATES: _____

Coloque una **CRUZ** al lado de los documentos específicos a los cuales aplica su solicitud/Put a **CHECKMARK** next to the specific documents that apply to your request:

Notas de la clínica ambulatoria/Outpatient Clinic Notes	Notas de progreso del paciente interno/Inpatient Progress Notes	Notas de enfermería/Nurses Notes	Consultas/Consultations
Notas del departamento de emergencia/Emergency Dept. Notes	Notas operativas/del procedimiento/Operative Procedure Notes	Informe de alta/Discharge Summary	Imágenes/Disco compacto/Film / CD
Notas del centro de cuidado urgente/Urgent Care Center Notes	Reportes de patología/Pathology Reports	Reportes de laboratorio/Lab Reports	Otro/Other:
Historia y examen físico/History and Physical.	Órdenes del médico/Provider Orders	Reportes de radiología/Radiology Reports	

Escriba sus **INICIALES** al lado de la información PRIVADA a la que se refiere su solicitud/Put your **INITIALS** next to any SENSITIVE information that pertains to your request.

Salud mental/Mental Health	Drogas y Alcohol/Drugs & Alcohol	VIH/SIDA/otras enfermedades contagiosas/HIV/AIDS, Other Communicable Diseases	Pruebas genéticas/Genetic Testing	No aplica/Not Applicable
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Coloque una **CRUZ** al lado del propósito de su solicitud/Put a **CHECKMARK** next to the purpose of the request:

<input type="checkbox"/>	Abogado/Legal Attorney/ Legal
<input type="checkbox"/>	Uso personal/Personal Use

<input type="checkbox"/>	Continuación de cuidados del paciente/Continued Patient Care
<input type="checkbox"/>	Servicios Sociales/Incapacidad Social Services./ Disability.

<input type="checkbox"/>	Seguro/ Insurance
<input type="checkbox"/>	Otro/Other:

Coloque una **CRUZ** al lado de cómo quisiera recibir lo que solicitó/Put a **CHECKMARK** next to how you would like to receive your request:

<input type="checkbox"/>	Por correo a la dirección arriba/Mail to above address.
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<input type="checkbox"/>	Recoger los expedientes/Pick up records.
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<input type="checkbox"/>	Revisar los expedientes en <i>Release of Information Dept.</i> (no copias impresas)/Review records in Release of Information department at hospital (No printed copies).
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ENTIENDO QUE:

- Puedo revocar esta autorización en cualquier momento:
 - Esta revocación no incluye aquella información que ya ha sido divulgada como respuesta a esta autorización.
 - Debo revocar esta autorización por escrito. El procedimiento para revocar esta autorización consiste en presentar mi revocación por escrito ante el *Medical Information Management Department*.
- Puedo negarme a firmar esta autorización:
 - *UNC Health Care System* no pondrá como condición la firma de esta autorización para mi tratamiento, pagos, inscripción en un plan de salud o ser acreedor a los beneficios.
 - Pueda que se cobren honorarios para obtener una copia de la información de salud protegida. Favor de comunicarse con *Copy Service* al 919-966-4521 para conocer el costo y la tarifa.

He sido informado y entiendo que la información divulgada como consecuencia de esta autorización puede ser redivulgada por el destinatario de dicha información. Es posible que una vez que haya sido divulgada, la privacidad de la información ya no esté protegida bajo la ley federal de la privacidad médica

A menos que esta autorización sea revocada con anterioridad se vencerá en la fecha, o por el evento o condición siguientes /Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____. Si no especifico una fecha de vencimiento, o un evento o condición, esta autorización se vencerá automáticamente a los noventa (90) días posteriores a la fecha en que se firmó / If 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.

He leído y entendido la información en este formulario de autorización/I have read and understand the information in this Authorization form.

Firma del paciente/Signature of Patient:	
Nombre en letra de imprenta/Printed Name:	Fecha/Date:

O/OR

Firma del representante autorizado/Signature of Authorized Representative:	
Nombre en letra de imprenta/Printed Name:	Fecha/Date:
Favor de explicar la autoridad del representante para actuar en nombre del paciente/Please explain Representative's authority to act on the behalf of the Patient: _____ _____	

Office Use Only

Ed. On Fee: _____	Call for: _____	Pickup _____	Review _____
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UNC Health Care System
101 Manning Drive, Chapel Hill, NC 27514
RELEASE OF MEDICAL INFORMATION AUTHORIZATION FORM – MIM #710-S

I authorize:

	UNC Health Care System
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OR

	Other:
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To use or disclose to:

Name	Address
City	State
	Zip Code

the protected health information of

Patient Name: _____ Date of Birth: ____/____/____

Address: _____ City: _____ State: _____ Zip Code _____

Telephone: (____) _____ Social Sec. # (last 4 digits only): _____

UNC HCS Medical Record # _____ TREATMENT DATES: _____

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

	Outpatient Clinic Notes
	Emergency Dept. Notes
	Urgent Care Center Notes
	History and Physical

	Inpatient Progress Notes
	Operative/Procedure Notes
	Pathology Reports
	Provider Orders

	Nurses Notes
	Discharge Summary
	Laboratory Reports
	Radiology Reports

	Consultations
	Film / CD
	Other:

Put your INITIALS next to any SENSITIVE information that pertains to your request.

	Mental Health
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	Drugs & Alcohol
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	HIV/ AIDS, Other Communicable Diseases
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	Genetic Testing
--	-----------------

	Not Applicable
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Put a CHECKMARK next to the purpose of the request:

	Attorney/ Legal
	Personal Use

	Continued Patient Care
	Social Services/ Disability

	Insurance
	Other:

Put a **CHECKMARK** next to how you would like to receive your request:

	Mail to above address.		Pick up records.		Review records in Release of Information department at hospital (No printed copies).
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I UNDERSTAND THAT:

- I may revoke this Authorization at any time:
 - the revocation will not apply to information that has already been released in response to this Authorization
 - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the Medical Information Management Department.
- I may refuse to sign this Authorization:
 - UNC Health Care System will not condition my treatment, any payment, enrollment in a health plan, or eligibility for benefits on receiving my signature on this Authorization.
 - A fee may be charged for copying the protected health information. Please contact Copy Service to obtain fee and rate information @ 919-966-4521

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It 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:_____. If 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:

OR

Signature of Authorized Representative:	
Printed Name:	Date:
Please explain Representative’s authority to act on the behalf of the Patient:	

Office Use Only	
Ed. On Fee: _____	Call for: _____ Pickup _____ Review _____