Duke Integrative Medicine
DUMC 102904
Durham, NC 27710
Phone: 919-660-6826
Fax: 919-681-0380

Patient Name: _____

Duke MRN _____

Date of Birth: _____

Authorization for Release of Medical Information

THIS FORM MUST BE COMPLETED IN FULL

(Please fill out a separate form for each doctor or hospital request to release information)

I authorize and request: _____
(Name of doctor or hospital **RELEASING** information)

_____
(Address)

_____ _____
(Telephone #) (Fax #)

Release to: _____**Duke Integrative Medicine**_____
(Name of doctor or hospital TO RECEIVE information)

The following information for the **dates of service** from _____ through _____.

Information to be released (check all that apply)**:**

___ ENTIRE Record ___ Office Visit Note(s) ___ Procedure Note(s)
___ Laboratory Reports ___ Radiology Reports ___ Immunization Records
___ Other: _____
___ Medical information pertinent to treatment for alcohol, drug abuse, or psychological assessment and/or treatment for the periods from _____ through _____.

Purpose of this release (Check all that apply):

___ Continuation of Care ___ Insurance processing
___ Legal ___ Personal use
___ Other (specify): _____

I Understand That:

- ***The information to be released may include a diagnosis or reference to the following conditions: sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV).***
- Without my express revocation, this Authorization will automatically ***expire*** one year from the date signed below, unless I request an expiration date less than one year.
- I may ***revoke*** this authorization in writing at any time, except to the extent that action has already been taken to comply with it. 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.
- Information disclosed pursuant to the authorization may be subject to ***redisclosure*** by the recipient and may no longer be protected by the HIPAA Privacy Rule.

Note: The patient is responsible for any charges incurred in relation to this request of records.

Signature: My signature is required to validate this Authorization. If I do not sign this authorization, Duke University, Duke University Health System, and the Private Diagnostic Clinic, PLLC will still provide treatment and seek payment for services provided. According to the North Carolina General Statutes, Health Information Management may charge for copies of medical records. **This authorization will expire on _____.**

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient's Legal Representative (if applicable) * Relationship to Patient

*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.

The information in this Fax may contain sensitive, protected health information intended only for the addressee(s). Any other person, including anyone who believes he/she