M3132
Rev. 3/2025

DukeHealth

AUTHORIZATION FOR RELEASE OF INFORMATION

Place Patient Label Here
(For Internal Use Only)

If for oral communication, fill out Verbal Release of Information Authorization

PART A: PATIENT INFORMATION

Legal Patient Name (Required): Preferred Name:

Date of Birth: Medical Record #: SS# (Last 4 Digits):

Email: Phone:

Address: City: State: Zip:

PART B: PERSON OR COMPANY WHO WILL RECEIVE INFORMATION

☐ Self (Same Info As Above)

☐ Person or Entity: _____ Phone: _____

Email: Fax:

Address: City: State: Zip:

PART C: INFORMATION TO BE RELEASED (Check All That Apply)

Treatment Location:

☐ Duke University Hospital
☐ Duke Regional Hospital
☐ Duke Lake Norman Hospital
☐ Duke Raleigh Hospital, *a campus of Duke University Hospital*
☐ Duke Clinic (Specify Location) _____
☐ All Duke Health Enterprise Entities

Treatment Date(s): Last 2 years of active treatment will be provided unless specified.

☐ From _____ to _____ (Please Be Specific) ***Or*** ☐ All Treatment Dates

Records or Information: If sending to a provider, an Abstract/Summary of records will be sent unless otherwise marked below.

☐ **Abstract/Summary** *(Includes Items in **Bold**)* ***Or*** ☐ Entire Record ***(Does Not Include Billing or Imaging)***

☐ **Discharge Summary**
☐ **History and Physical**
☐ **Clinic Visit**
☐ **Radiology Reports**
☐ **Consultation Report**
☐ **Operative/Procedure Report**
☐ **Laboratory Reports**
☐ **Pathology Reports**
☐ **Emergency Department Record**
☐ **Physical/Occupational Record**
☐ Immunization Record

☐ Billing Records
☐ Radiology Images (CD only)
☐ Cardiology Images (Echo, Cath Lab)
☐ Neurology Images (EEG)
☐ Other Imaging _____

PART D: PURPOSE OF REQUEST

☐ Personal ☐ Legal ☐ Insurance ☐ Continuation of Care ☐ Other (specify): _____

PART E: FORMAT AND DELIVERY OF INFORMATION (Select One Option)

Electronic Delivery
☐ My Duke Health (Patients Only)
☐ Portal (Attorney/Insurance)
☐ Encrypted Email *(Provide in Part B)*
☐ Fax *(Provide in Part B)*

Mail Delivery
☐ CD (Charges may apply)
☐ Paper (Charges may apply)

PART F: REVIEW AND APPROVAL

I understand that the information to be released may include reference to sensitive information related to mental and behavioral health, genetic testing, HIV/AIDS or other communicable diseases. I specifically approve the release of the following information that has been marked as sensitive and/or restricted (check all that apply):

☐ Mental and Behavioral Health ☐ Genetic Testing

I understand that I may revoke this Authorization in writing at any time, except to the extent that action has already been taken in response to the Authorization. I understand that the information released pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy law. I understand that I may refuse to sign this Authorization. If I do not sign this Authorization, Duke Health will continue to provide treatment and seek payment for services provided. Duke Health may charge a fee for providing the information specified above.

This Authorization will automatically expire one year from the date signed below unless revoked or another date or event is written here:

Signature of Patient/Patient Representative	Printed Name	Date
Relationship (if not signed by Patient)	Phone Number (if different from above)	

If you are not the patient or the parent of a minor patient, you MUST attach documentation of your authority to act on behalf of the patient (Power of Attorney, Court Order, Legal Guardian Documentation, Executor/Administrator Documentation)

SEND COMPLETED FORM TO **ONE** OF THE FOLLOWING:
Fax: 919-620-5165 ; ROI-requestor3@dm.duke.edu; For Questions Call: 919-684-1700;
Duke University Hospital - HIM, DUMC Box 3016, Durham, NC 27710