The University of North Carolina at Chapel Hill

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ PID #: _____

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

Phone #: (___) _____ Email: _____

I request and authorize:

☐ UNC Wellbeing Administrative Services ☐ UNC Counseling and Psychological Services (CAPS)

To release the Protected Health Information of the patient named above to:

☐ UNC Health Campus Care ☐ Other: Name: _____

☐ Patient Address: _____

Fax : _____ Phone: _____

Email: _____

How information is to be released:

☐ Patient Pickup ☐ Mail to address above ☐ Fax to number above ☐ Email to address above

Information to be Released

☐ Campus Health Medical Records Prior to August 1, 2026
☐ Immunization Records Only Prior to August 1, 2026
☐ Counseling and Psychological (CAPS) Records
☐ Prescription History
☐ Other:

For non-CAPS medical records created after August 1, 2026 – contact UNC Health at relmedinfo@unchealth.unc.edu or 919-984-3226

Purpose of the Release

☐ Continuing Medical or Mental Health Care
☐ Insurance/Billing
☐ Legal/Attorney Request
☐ Parental/Guardian Communication
☐ Personal Use
☐ Provider-to-Provider Communication
☐ Other:

Treatment/service date(s) for requested information: _____

Continue Reverse →

Patient Name: _____ PID #: _____

I understand that:

- I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing.
- 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 Wellbeing Administrative Services.

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 (Electronic signatures not accepted)	Printed Name	Date

OR if patient is under the age of 18

_____	_____	_____
Signature of Authorized Representative	Printed Name	Date

Please explain Representative's authority
to act on behalf of patient: _____

Forward Completed Form To:
Wellbeing Administrative Services
University of North Carolina at Chapel Hill
320 Emergency Room Dr.
Chapel Hill, NC 27599-7470
Fax (919) 966-0616 | Phone (919) 966-2283
Email: campushealth_records@unc.edu