UNC SCHOOL OF MEDICINE

# TEACCH Autism Program

*Mailing Address:*
TEACCH Greensboro Center 925
Revolution Mill Drive, Suite 7
Greensboro, NC 27405
Fax: 919-445-2354

**ATTENTION: RELEASE OF MEDICAL INFORMATION AND CONFIDENTIALITY AUTHORIZATION FORM**

***Please check one:***
I authorize TEACCH to ☐ obtain/use ☐ disclose to ☐ to both obtain and disclose to

***Please check if this applies:***
I authorize TEACCH to correspond via email* ☐ with me ☐ with person listed below

***to disclose or obtain:***

| | | |
|---|---|---|
| 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 | Email: | |

***Put a <u>CHECKMARK</u> next to any specific documents that apply to the request:***

| | | |
|---|---|---|
| ☐ Intervention Summary | ☐ Cognitive Testing Report | ☐ Pediatric/ Medical records |
| ☐ Diagnostic/ Assessment Report | ☐ Educational Testing Report | ☐ IEP |
| ☐ Consultation Report | ☐ Other: | |

***Put a <u>CHECKMARK</u> next to the purpose of the request:***

| | | |
|---|---|---|
| ☐ Attorney/Legal | ☐ Continued Patient Care | ☐ Insurance |
| ☐ Diagnostic Clarification | ☐ Social Services/Disability | ☐ Educational |
| ☐ Determination of Eligibility for TEACCH Services | ☐ Other: | |

***Put a <u>CHECKMARK</u> next to how the above document(s)/information may be sent/obtained:***

| | | |
|---|---|---|
| ☐ Mail to Address Listed for Person or Facility | ☐ FAX to # Listed Above (Urgent or Prioritizes) | ☐ Email to Address Listed for Person or Facility* |
| ☐ Mail to Patient Address | ☐ Pick Up at TEACCH Office | ☐ Verbal |
| ☐ Other: | | |

*E-mail communications that contain sensitive information must be sent in a "secure" manner as determined by the TEACCH Information Technology Professional(s). However, once received by an individual outside the UNC system (such as to a

"GMAIL" account), the transmission is no longer secure and UNC will not be responsible for any breach, improper disclosure or loss of the information.

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 TEACCH 925 Revolution Mill Drive, Suite 7, Greensboro NC 27405
- I may refuse to sign this authorization:
  - TEACCH and the 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 of the protected health information

I have been informed and understand that 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 medical privacy law.

Unless otherwise revoked according to the above directions, this authorization will expire on the following date, event, or condition: _____or upon the satisfaction of the need for disclosure: _____.

If I fail to specify an expiration date, event or condition, this authorization will not expire.

**I have read and understand the information in this authorization form.**

| Signature of Individual:<br>*if over 18 years of age* | |
|---|---|
| Printed Name: | Date: |

**-OR-**

| Signature of<br>Authorized Representative: | |
|---|---|
| Printed Name: | Date: |
| Please Explain Representative's Relationship To The Individual: | |