



Wake Forest Location
 1655 Wake Drive, Suite 101
 Wake Forest, NC 27587

Knightdale Location
 4019 Village Park Drive
 Knightdale, NC 27545

Office 919-556-4779
 Fax 919-556-5277

Office 919-266-5059
 Fax 919-266-4309

**AUTHORIZATION FOR THE USE AND DISCLOSURE OF
 PROTECTED HEALTH INFORMATION**

I hereby authorize the practice listed below to Disclose my Protected Health Information as described below to **Wake Forest Pediatric Associates, PLLC**. Please mark check box above to indicate which location should receive a copy of the patients records.

 Practice/Doctor

 Address City, State & Zip Code

 Office Number Fax Number

Please release (Dates Needed _____):
 _____ entire medical record
 _____ immunizations only
 _____ progress notes only
 _____ labs only

Patient: _____ Date of Birth _____

PURPOSE OF DISCLOSURE: _____

I understand that in the event I was treated for drug or alcohol abuse, a psychiatric condition and/or communicable diseases including HIV/AIDS this information will be included as part of my medical record to the above-named person/facility. Wake Forest Pediatric Associates, PLLC may not condition treatment, payment, enrollment or eligibility for benefits on signing this authorization.

This authorization is subject to cancellation/revocation at any time by the patient or legally qualified representative provided that the cancellation is made in writing except to the extent that:

1. The facility has already acted on your request prior to receiving the request to cancel the authorization: or
2. If the authorization was given to release records to your insurance company in order to obtain insurance coverage.

NOTE: Depending on office policy, there may be a charge for medical records. NC GS 90-411 states a facility can charge (75¢) per page for the first 25 pages, (50¢) per page for pages 26 – 100, and (25¢) for each page in excess of 100 pages. Please contact your previous doctor to confirm if there is a charge.

Signature: _____ Date: _____

Relationship to patient: _____

Expiration Date: _____. **This authorization will automatically expire in 90 days unless otherwise noted.**