Wake Forest Pediatric Associates, PLLC

1655 Wake Drive, Suite 101
Wake Forest, NC 27587

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

______________________________ (Print patients full name)

______________________________ Birth date (Mo/Day/Yr)

______________________________ (Street address)

______________________________ Social security number

______________________________ (City, state, zip code)

______________________________ Phone (Home)

At the request of the individual, I ____________________ (patients name), do hereby authorize ____________________ (name of facility) to release:

_____DISCHARGE SUMMARY
_____HISTORY & PHYSICAL
_____PROGRESS NOTES
_____OPERATIVE NOTES
_____PATHOLOGY REPORTS
_____LABORATORY REPORTS
_____RADIOLOGY REPORTS
_____ECG/EEG/CARDIC CATH
_____EMERGENCY REPORTS
_____OTHER____________________

From the time period of ____________________ to ____________________

_____ I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

______________________________ Name of Company/Agency/Facility/Person

______________________________ Street address

______________________________ City, state, zip

PURPOSE OF DISCLOSURE:

_____REFERRAL TO SPECIALIST
_____LEGAL INVESTIGATION
_____INSURANCE
_____DISABILITY DETERMINATION
_____WORKERS COMP
_____PERSONAL
_____CHANGE OF DOCTOR
_____CONTINUING CARE
OTHER (SPECIFY)____________________

Please provide current daytime telephone number in the event we need to contact you: ____________________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

____
Signature of individual or guardian or Personal Representative of patient's estate

____
Date

PLEASE NOTE: THERE IS A CHARGE FOR MEDICAL RECORDS WHEN REQUESTED FOR PERSONAL REASONS OR PERMANENT TRANSFER. SMART DOCUMENT SOLUTIONS HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY. QUESTIONS MAY BE DIRECTED TO 1-800-464-0035.

MEDICAL INFORMATION RELEASED BY SMART DOCUMENT SOLUTIONS

ENTIRE_______ LAB_______ EKG_______
DS_______ EKG_______ IMMUNE_______
OP_______ X-Ray_______ CLINIC_______
HP_______ PATH_______ OTHER_______

____
ROI SPECIALIST DATE

NUMBER OF PAGES ____________

Smart Document Solutions processes written requests for medical information that accompany a signed authorization from the patient, legal guardian if a minor, or power of attorney.

Some examples of billable requests are as follows:

- insurance companies
- third party adjusters
- attorneys
- transferring patients (see below)
- state agencies such as DDS, Voc Rehab, Social Security Administration

Patient Rates are as follows:
$0.75 per page for pages 1 -25
$0.50 per page for pages 26 – 38
$0.15 per page for pages 39+

Plus actual postage.

This fee is for a personal copy or for the permanent transfer of records. Patients are pre-billed, records are released once the invoice has been paid or 30 days has past.

Smart Document Solutions does not bill if records are needed for a continuing care purposes. Urgent requests should be handled directly by the medical staff and should not be given to SDS. Some examples of courtesy requests are as follows:

- records needed for a referred specialist
- records sent to a sister facility
- home health services
- non-profit organizations (adoption agencies, etc.)
- schools and developmental programs
- medicare requests
- hospitals
- hospice
- special health units (psychiatric, etc.)
- health departments
- social services