

Wake Forest Pediatric Associates, PLLC

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

Knightdale Location
6845 Knightdale Boulevard, Suite 100
Knightdale, NC 27545

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, OTHER (SPECIFY), INSURANCE, DISABILITY DETERMINATION, WORKERS COMP, PERSONAL, CHANGE OF DOCTOR, CONTINUING CARE

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. 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. HEALTHPORT 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 HEALTHPORT

ENTIRE, DS, OP, HP, LAB, EKG, X-Ray, PATH, EKG, IMMUNE, CLINIC, OTHER, ROI SPECIALIST, DATE, NUMBER OF PAGES