Wake Forest Location
1655 Wake Drive, Suite 101
Wake Forest, NC 27587
office: **919.556.4779**
fax: **919.556.5277**

Knightdale Location
6845 Knightdale Blvd., Ste. 100
Knightdale, NC 27545
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. Place a check mark beside the location above you wish to receive a copy of your child's medical records.***

_____

Previous Practice/Doctor Name

_____

Address City, State & Zip Code

_____ _____

Office Number Fax Number

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

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

Patient:_____Date of Birth _____

PURPOSE OF DISCLOSURE: _____

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.