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 __________________, do hereby authorize _________________________ to release:
(patients name) (name of facility)

______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 ______INSURANCE ______WORKERS COMP ______CHANGE OF DOCTOR
______LEGAL INVESTIGATION ______DISABILITY DETERMINATION ______PERSONAL ______ 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 affect 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. CIOX 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 CIOX

ENTIRE_______ LAB________ EKG____________
DS___________ EKG________ IMMUNE________
OP___________ X-Ray_______ CLINIC__________
HP___________ PATH_______ OTHER___________________________

____
ROI SPECIALIST DATE

NUMBER OF PAGES _______________