Wake Forest Pediatric Associates, PLLC

_____Wake Forest Pediatrics, 1655 Wake Drive, Suite 101, Wake Forest, NC 27587 PH: 919-556-4779 Fax: 919-556-5277
_____Knightdale Pediatrics, 6845 Knightdale Boulevard, Suite 100, Knightdale, NC 27545 PH: 919-266-5059 Fax: 919-266-4309

AUTHORIZATION TO USE/RELEASE/DISCLOSE MEDICAL INFORMATION

PLEASE ALLOW 5 BUSINESS DAYS FOR ALL MEDICAL RECORDS REQUESTS TO BE PROCESSED

_____ _____
(Print patient's full name) Birth date (MM/DD/YYYY)

_____ _____
(Street address) Social security number

_____ _____
(City, state, zip code) (Preferred contact number)

_____DISCHARGE SUMMARY _____SPECIALIST NOTES _____EMERGENCY REPORTS
_____HISTORY & PHYSICAL _____LABORATORY REPORTS _____OTHER _____
_____OFFICE NOTES _____RADIOLOGY REPORTS _____
_____OPERATIVE NOTES _____PSYCHOLOGICAL REPORTS

- **If this request is for any patient 18 years or older, the form must be signed by the patient (unless Healthcare Power of Attorney paperwork is provided)**
- **PLEASE MAIL ANY RECORDS CONSISTING OF MORE THAN 30 PAGES**

_____ ALL RECORDS or, 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.

_____ REQUEST INFORMATION FROM: **_____ RELEASE INFORMATION TO:**

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

_____
Phone

_____
Fax/Email

PURPOSE OF DISCLOSURE:
_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKER'S 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.

_____
Printed name of individual, guardian, or Personal Representative of patient's estate

_____ **Date:** _____
Signature of individual, guardian, or Personal Representative of patient's estate