210PETImaging

raleigh radiology | WakeMed

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

Daytime phone number: _____

Please complete all bolded sections

Select ONE of the following:

☐ 210 PET Imaging to provide medical information; or
☐ 210 PET Imaging to obtain medical information from _____

A. Reason for request (select ONE of the following): ☐ Continued care ☐ Insurance ☐ Attorney ☐ Personal use
☐ Other _____

B. Information needed (select from below - a fee may be charged for copies of an entire encounter or all records)
☐ History & Physical ☐ X-ray Report ☐ Office Note (clinic only)
☐ Other _____

C. Date of encounter or visit: _____

D. Way to provide information: ☐ Paper copy ☐ CD ☐ Onsite Review

E. How to share information:
☐ Pick up Name of person to pick up or receive information: _____
☐ Mail Address: _____
☐ Fax Fax Number including area code (patient care only): _____

I understand the medical information to be disclosed may include information/results regarding psychological or psychiatric impairment, sexual assault, alcohol abuse, drug abuse, and/or a communicable disease including HIV/AIDS. I understand that I may revoke (cancel) this authorization at any time except to the extent that the information has already been released pursuant to this authorization and before I have revoked my authorization. If I revoke this authorization, I must do so in writing to the WakeMed Medical Record Services Department. I understand that treatment will not be conditioned upon my completion of this authorization. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information and would no longer be protected under the terms of the federal privacy rule.

Patient Signature: _____ **Date Signed:** _____

When someone other than the patient signs, the following must be completed:

I, _____ (print your name) hereby certify and attest that I am the duly authorized personal representative of the above patient, and that I have the lawful authority to enter into this authorization on behalf of such individual. I understand proof of this authority may be requested. I have read the provisions set forth in this authorization, and agree that 210 PET Imaging may disclose the medical information of such individual for the purposes set forth herein.

Signature of Representative: _____ **Date Signed:** _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Executor of estate ☐ Power of Attorney
☐ Other _____

Reason patient unable to sign: _____

Remaining Section to be completed by 210 PET Imaging Staff

Date information released: _____ Initials of who completed release: _____

Patient Number: _____ Medical Record Number: _____ Division: _____