# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**Patient Name:** _____ **Date of Birth:** _____ Daytime phone number: _____

***Complete all bolded sections***

**Select ONE of the following:** ☐ WakeMed to provide medical information; or
☐ WakeMed 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)**

☐ Discharge Summary ☐ History & Physical ☐ Emergency Room Visit
☐ Labs ☐ Radiology (☐ Images ☐ Reports) ☐ Operative Note/Procedure Note
☐ Pathology ☐ Office Note (WPP) ☐ Immunization/Vaccination
☐ Hospital Admission (Abstract) ☐ Other _____

**C. Date of encounter or visit:** _____

**D. Way to provide information:** ☐ Paper ☐ CD ☐ Onsite Review ☐ Verbal ☐ MyChart
☐ Email (Encrypted/Unencrypted) _____
Communication that is sent unencrypted, PHI can be intercepted by unauthorized parties.

**E. How to share information:** ☐ Pick up ☐ Mail ☐ *Fax ☐ Verbal ☐ Radiology Images via Powershare

Name of person to pick up or receive information: _____

Address: _____

*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 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:** _____

**This Authorization will automatically expire 90 days from the date signed unless revoked or another date or event is written here:**

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

I, _____ (print 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 WakeMed may disclose the medical information of such individual for the purposes set forth herein.

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

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

**Reason patient unable to sign:** _____

**Remaining Section to be completed by WakeMed Staff**

Date Information Released: _____ Initials of who completed release: _____

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

Patient Label

**WakeMed**
**Authorization to Release Medical Information**