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 copies
☐ WakeMed to obtain copies from ____________________

Select one box in all sections:

A. Reason for request ☐ Continued care ☐ Insurance ☐ Attorney ☐ Personal use ☐ Other ____________

B. Information needed - not all may apply and a fee may be charged

☐ Discharge Summary ☐ History & Physical Examination ☐ Emergency Room Record
☐ Lab Report ☐ X-ray Report ☐ Operative Report/Procedure Note
☐ Pathology Report ☐ Office Note (clinic only) ☐ Immunization/Vaccination Records
☐ 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 information: ____________________
☐ Mail Name: ____________________
Address: ____________________
☐ Fax (Patient Care Only) Name: ____________________
Fax Number including area code: ____________________

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. Unless otherwise revoked, this authorization will automatically expire 90 days after the date signed. 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 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 WakeMed may disclose the medical information of such individual for the purposes set forth.

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 WakeMed Health & Hospitals Staff

Date Information Released: ____________ Initials of who completed release: ____________
Patient Number: ____________ Medical Record Number: ____________ Division: ____________

Patient Label placed here

WakeMed
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