WakeMed

Authorization to Release Medical Information

I AUTHORIZE WAKEMED TO (Select one) ☐ RELEASE OR ☐ OBTAIN MY PROTECTED HEALTH INFORMATION (PHI)

For the PURPOSE (Select one) of ☐ Billing/Insurance ☐ Patient Care ☐ Personal ☐ Legal ☐ Other: _____

PATIENT/RECIPIENT INFORMATION (Print)

Patient

Patient's Name _____ Patient's Date of Birth _____

Recipient's Contact Information

Name of Person, Organization, or Facility you want us to release your PHI to or obtain your PHI from _____

Address where you want your PHI sent to _____

City _____ State _____ Zip Code _____

Phone # _____ Fax # (Health care providers only) _____

Email address _____

PHI TO BE RELEASED/OBTAINED

Date(s) of Visit

_____
Specify the date, date range, or other specific description of your visit

Requested Records (Select any that apply)

☐ Office Visit ☐ Urgent Care Visit
☐ Op Note ☐ Immunizations
☐ Consultations ☐ Other (specify): _____

☐ Hospital Admission and/or ED Visit
☐ Hospital Admission and/or ED Visit Abstract (*Includes all, or select separately)
☐ *Discharge Summary ☐ *History and Physical
☐ *Laboratory Reports ☐ *Radiology Reports

☐ Imaging study (When you request that your imaging studies be sent to a health care provider, the image will be electronically shared. If your provider is unable to receive via PowerShare a CD will be mailed to the provider.)

Format (Select one) ☐ Paper Copy or ☐ Electronic Copy (includes CD, MyChart, PDF via email)

Delivery Method (Select one) ☐ Mail ☐ Fax ☐ Pick up ☐ Onsite Review (by appointment only)

☐ MyChart (for dates of service on or after 2/1/2015)

☐ Email: Communications via email may not be secure. There is a possibility that information included in an email can be intercepted and read by other parties beside the person to whom it is addressed. Therefore, we encrypt your email unless you check this box for ☐ unencrypted email.

SEND COMPLETED FORM TO: HIMROI@Wakemed.org; Fax: 919-350-1720
OR WakeMed Health & Hospitals-HIM Department, 3000 New Bern Avenue, Raleigh, NC 27610;
For Questions Call: 919-350-8370

Place Patient Label Here

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UNDERSTANDING

I understand the PHI disclosed may include information/results regarding psychological or psychiatric impairment, sexual assault, alcohol abuse, drug abuse, a communicable disease including HIV/AIDS, genetic testing, and/or reproductive health.

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 Health Information Management 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.

I understand that requests for "any and/or all" records, and other large volume requests are sent to WakeMed's copy service for processing. I understand a fee will be charged for these records.

AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby certify and attest by my signature on this authorization that I am the patient or duly authorized personal representative of the above patient with the authority to enter this authorization on behalf of such individual. I understand proof of my identity and 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.

_____ _____

Patient's Signature **Date**

_____ _____

Printed Name of Personal Representative **Signature of Personal Representative**

_____

If you are a Personal Representative explain your relationship/authority to act on behalf of the patient

REVOCATION

Unless previously revoked, this Authorization will expire on the following date, event or condition: (list date, event condition) _____.

If I fail to specify an expiration date or event or condition, this Authorization shall remain in effect for ninety (90) days from the date I sign it.

CONTACT US

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