Wake Gastroenterology
Wake Women's Health
Wake Internal Medicine Consultants, Inc.
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Wake Sports Medicine Nonsurgical Orthopedics
Wake Internal Medicine & Pediatrics

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10880 Durant Road, Ste. 100 Raleigh, NC 27614

Authorization to Release Medical Records **from Wake Internal Medicine** /or its divisions

I authorize Wake Internal Medicine Consultants, Inc., or one of its divisions, to use and disclose a copy of the specific health and medical information described below regarding:

_____ _____ __XXX_-_XX_-_____
Patient name **Date of birth** **Social Security Number**

Address: _____ **City/State/Zip Code**: _____

Patient Phone # _____

Consisting of:

☐ **Last 2 years of records** **OR**

- ☐ Most recent history & physical /consult reports/hospital history & physical/discharge summary
- ☐ Most recent Laboratory Reports
- ☐ Most recent EKG/2D Echo/ Stress Echo/Carotid Doppler
- ☐ ABI's/Angiograms/cardiac catheterization
- ☐ Pulmonary Function Test
- ☐ X-ray/CT/Ultrasound/MRI reports
- ☐ 2 most recent DEXA scans
- ☐ Most recent Mammogram
- ☐ Most recent colonoscopy/path
- ☐ Most recent EGD/path
- ☐ Vaccination Record
- ☐ Other _____

Release information to: _____
Name of Company/Agency/Facility/ Person

Address: _____

City/State/Zip: _____

Office Phone #: _____ Office Fax #: _____

For the purpose of: (This MUST be completed to process your request)

☐ Referral to specialist ☐ Insurance ☐ Worker's Comp ☐ Legal
☐ Disability Determination ☐ Personal Copy ☐ Specialty Office
☐ Change of Primary Care Doctor (please give reason): _____
☐ Other (specify) _____

I hereby authorize disclosure of the health information of the above named patient. **This authorization is valid for 180 days 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 of facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization. I understand that this includes the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency)

_____
I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: _____ _____ Date: _____
Patient's printed name Patient's Signature

Or By: _____ _____ Date: _____
Patient's Representative Signature

Description of Representative's Authority: _____

*** Please note that there will be a charge for providing copies when transferring or for personal use.**