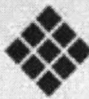
WAKE GASTROENTEROLOGY

Wake Women's Health



Wake Internal Medicine Consultants, Inc.

919.781.7500

WAKE SPORTS MEDICINE
NONSURGICAL ORTHOPEDICS

Wake Internal Medicine & Pediatrics

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

I authorize: ______________________________
Name of Company/Agency/Facility/ Person

Address: ______________________________

City/State/Zip: ______________________________

To release a copy of the specific health and medical information described below:

______________________ Patient name

______________ Date of birth

XXX - XX - ________ 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: **Wake Internal Medicine Consultants, Inc.**

☐ **3100 Blue Ridge Rd., Ste.** 203
Raleigh, NC 27612
Phone: 919 719 2270
***Fax Ste.** 919 719 2271
Attn: ____________________

☐ **10880 Durant Rd., Ste. 100**
Raleigh, NC 27614
Phone: 919-781-7500
***Fax: 919-420-6065**
Attn: ____________________

* ***If more than 20 pages, please mail***

For the purpose of:

☐ Referral to specialist ☐ Insurance ☐ Personal Copy
☐ Change of Primary Care Doctor ☐ 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 may be a charge from the facility providing records**