



AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

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

Patient Name _____ Date of Birth / / Social Security Number - -

Patient Address: _____
Street City State Zip Code

Consisting of: (Check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Emergency Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Radiology Reports | _____ |
| <input type="checkbox"/> Operative Notes | <input type="checkbox"/> ECG/EEG/Cardiac Cath | _____ |

From the period of _____ to _____.

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

Address

City/State/Zip Code

For the purpose of: (please check any that apply)

- | | | | |
|---|------------------------------------|--|--|
| <input type="checkbox"/> Referral to specialist | <input type="checkbox"/> Insurance | <input type="checkbox"/> Worker's Comp | <input type="checkbox"/> Legal Investigation |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Personal | <input type="checkbox"/> Continuing Care | |
| <input type="checkbox"/> Change of Doctor (please give reason): _____ | | | |
| <input type="checkbox"/> Other (specify) _____ | | | |

If we are requesting this Authorization from you for our own use and disclosure or to allow another health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provide that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

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 signature

Or by: _____ Date: _____
Patient's Representative

Description of Representative's Authority: _____

* Please note that there will be a charge for records when requested for personal reasons or permanent transfer.