



Authorization to Use & Disclose Health Information

I authorize: \_\_\_\_\_
Name of Company/Agency/Facility/ Person

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

To use and disclose a copy of the specific health and medical information described below regarding:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_/\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_/
Patient name Date of birth Social Security Number

Consisting of: (Check all that apply)

- Discharge Summary Pathology Reports Emergency Reports
History & Physical Laboratory Reports Other
Progress Notes Radiology Reports
Operative Notes ECG/EEG/Cardiac Cath ALL Records

From the period of \_\_\_\_\_ to \_\_\_\_\_.

Release Information to: Wake Women's Health
A Division of Wake Internal Medicine
3100 Blue Ridge Rd., Ste. 200
Raleigh, NC 27612
Phone: 919-719-2600 Fax: 919-714-6005

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

- Referral to specialist Insurance Worker's Comp Legal Investigation
Disability Determination Personal Continuing Care
Change of Doctor (please give reason):
Other (specify)

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or 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, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance of this Authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days form 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

Or By: \_\_\_\_\_ Date: \_\_\_\_\_
Patient's Representative

Description of Representative's Authority: \_\_\_\_\_

PLEASE NOTE THAT THERE MAY BE AN ADMINISTRATION CHARGE TO THE PATIENT FROM THE OFFICE SENDING RECORDS.