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:

_____ _____ 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: **Wake Internal Medicine Consultants, Inc.**

☐ **3100 Blue Ridge Rd., Ste. 300**
Raleigh, NC 27612
Phone: 919-781-7500
***Fax Ste. 300: 919-881-9586**
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**