940 SE Cary Parkway, Suite 200
Cary, NC 27518
Phone: (919) 859-9991
Fax: (919) 859-6595

AUTHORIZATION FOR WESTERN WAKE PEDIATRICS TO OBTAIN HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____ **Phone** _____

I authorize the provider/person below to release health information to **Western Wake Pediatrics:**

Person/Practice Name _____
Address: _____
Phone: _____ Fax: _____

Information to be Released
☐ Immunization records
☐ Medical record
☐ Growth charts
☐ School physical form
☐ Laboratory reports
☐ Radiology reports
☐ Other: _____

Dates of Service Requested
☐ All
☐ Most recent
☐ From _____ to _____

Reason for Release
☐ Patient request ☐ Transfer of care ☐ Continuity of care
☐ Other: _____

Authorization: I authorize the release of the records listed above to Western Wake Pediatrics.
Parent/Guardian Name: _____
Relationship to Patient: _____
Signature: _____ Date: _____

Acknowledgment: I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken. I understand information disclosed may be subject to re-disclosure and may no longer be protected by federal privacy regulations. I understand that I am not required to sign this authorization to receive treatment. This authorization also permits the exchange of information via fax, electronic transmission, or secure health information exchange. This authorization shall remain valid unless revoked and will expire one year from the date of signature unless otherwise specified here: _____

Delivery Requested
☐ Fax to (919) 859-6595
☐ Mail ***(required if documents exceed 30 pages)***
☐ Electronic by secure email to records@wwpeds.com