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Cary, NC 27518
Phone: (919) 859-9991
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AUTHORIZATION FOR WESTERN WAKE PEDIATRICS TO RELEASE HEALTH INFORMATION

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

I authorize **Western Wake Pediatrics** to release the following records:

☐ Last physical, Immunization records, growth charts and medical summary
☐ Records from dates _____ to _____
☐ Other _____

I do not authorize the release of the following sensitive health information. I understand that for any of the following boxes that are not checked, the health information released to the named recipient may include diagnosis, evaluation, treatment information for the following:

☐ Behavioral Health ☐ Alcohol or substance use ☐ Communicable diseases including HIV or AIDS

Information Release To

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

Reason for Release

☐ Patient Request ☐ Transfer of care ☐ Referral to specialist
☐ Other: _____

Delivery Requested

☐ Fax ☐ Mail ***(required if documents exceed 30 pages)*** ☐ Electronic by secure email to email address: _____
☐ Other: _____

Authorization

Parent/Guardian Name: _____
Relationship to Patient: _____
Signature: _____ Date: _____

Acknowledgment: I hereby authorize the use and disclosure of protected health information for the above-named patient. This authorization shall remain valid for one (1) year from the date of signature unless otherwise revoked in writing. I understand that I may revoke this authorization at any time by providing written notice; however, such revocation will not apply to information that has already been released in reliance on this authorization prior to receipt of the revocation. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations. I further understand that signing this authorization is voluntary and that my healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except as otherwise permitted by law.

If patient is 18 years of age or older, this release must be signed by them