WESTERN WAKE PEDIATRICS

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

COLLOBORATIVE CARE AUTHORIZATION FOR EXCHANGE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Parent/Legal Guardian: _____ **Phone:** _____

At the request of the individual, I authorize **Western Wake Pediatrics** to exchange confidential patient information on the patient listed above with:

Medical Specialist/School/Other_____

Phone: _____ Fax: _____

I understand the medical information to be disclosed may include information/results regarding psychological or psychiatric impairment, sexual assault, alcohol abuse, drug abuse, and/or a communicable disease including AIDS/HIV. I understand that I may revoke this authorization at any time except to the extent that the information has already been released pursuant to this authorization and before I have revoked my authorization. If I revoke this authorization, I MUST do so in writing to the Medical Records department of Western Wake Pediatrics. Unless otherwise revoked, this authorization is valid indefinitely. I understand that treatment will not be conditioned upon completion of this authorization. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information and would no longer be protected under the terms of the federal privacy rule.

Patient Signature: _____ **Date:** _____

When someone other than the patient signs, the following must be completed

I, _____ (print your name) hereby certify and attest that I am the duly authorized personal representative of the above-named patient, and I lawfully have the authority to enter this authorization on behalf of such individual. I understand proof of this authority may be requested. I have read the provisions set forth in this authorization and agree that Western Wake Pediatrics may disclose the personal health information of such individuals for the purpose of ongoing medical care.

Signature of representative: _____ **Date:** _____
Relationship to Patient ☐ Parent ☐ Guardian ☐ Other _____