



Wake Internal Medicine Consultants, Inc.
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Authorization to Release Medical Records from Wake Internal Medicine /or its divisions

I authorize Wake Internal Medicine Consultants, Inc., or one of its divisions, to use and disclose a copy of the specific health and medical information described below regarding:

Form fields for Patient name, Date of birth, Social Security Number, Address, City/State/Zip Code, and Patient Phone #.

Consisting of:

- List of checkboxes for medical records types: Last 2 years of records, Most recent history & physical, Laboratory Reports, EKG/2D Echo, Stress Echo/Carotid Doppler, ABI's/Angiograms, Pulmonary Function Test, X-ray/CT/ultrasound/MRI reports, DEXA scans, Mammogram, colonoscopy/path, EGD/path, Vaccination Record, and Other.

Release information to:

Form fields for Name of Company/Agency/Facility/ Person, Address, City/State/Zip, Office Phone #, and Office Fax #.

For the purpose of: (This MUST be completed to process your request)

- Checkboxes for Referral to specialist, Insurance, Worker's Comp, Legal, Disability Determination, Personal Copy, Specialty Office, Change of Primary Care Doctor, and 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 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: Patient's printed name, Patient's Signature, Date:

Or By: Patient's Representative, Signature, Date:

Description of Representative's Authority:

* Please note that there will be a charge for providing copies when transferring or for personal use.