Authorization to Release Medical Information

Wakefield Pediatrics & Adolescent Medicine, P.A.

Patient Information:

Print Name:_____DOB:_____

Address:_____

Healthcare Information coming from:

Wakefield Pediatric & Adolescent Medicine, P.A.
11081 Forest Pines Drive Suite 122
Raleigh, NC 27614

Please release my healthcare information to:
Name of Facility/Provider

_____

Street:_____
City/State/Zip_____
Phone/Fax#_____

Information to be released (please check the appropriate box)

___Immunization record ___Laboratory/Xray reports ___Consults ___Newborn screening/Newborn hearing result
___Growth Charts ___Psychiatric/Mental health/Drug/Alcohol ___Physician notes ___History/Physical
___Specific information (please specify)_____

Purpose for which disclosure is needed (please check the appropriate box)

___Transferring care to a new Primary Care Provider
___Insurance Carrier Issues
___Legal Investigation
___Personal/Other (please specify)_____
___Referral to Specialist

Patient Authorization

I understand that the information in my health record may include information relating to physical and/or mental illness, sexually transmitted infection, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). If requested in the future, Wakefield Pediatrics is specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Important Information when Transferring Care

I understand that as of the date I sign below, the above named patient will no longer receive care from Wakefield Pediatrics, P.A. This includes form completion, letter request, appointments or telephone calls including after hours calls. If the patient is interested in returning to Wakefield Pediatrics, P.A. in the future as a patient, they may only do so if the practice is accepting new patients.

Fees for Copying Medical Records

There is a charge for the photocopying of your records. Pre-payment is required prior to processing of records request.

PRINT NAME:_____

Signature:_____Date:_____Witnessed by:_____
(Patient/ Parent/Guardian/ Authorized Representative) (WPAM staff initials/date/time)

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE SIGNED