# Authorization to Release Medical Information

Wakefield Pediatrics & Adolescent Medicine, P.A.

**Patient Information:**

Print Name:________________________________________DOB:____________

Address:______________________________________________________

**Healthcare Information coming from:**

Name of Facility/Provider

______________________________

Street____________________________

City/State/Zip_______________________

**Please release my healthcare information to:**

**Wakefield Pediatric & Adolescent Medicine, P.A.**
**11081 Forest Pines Drive Suite 122 Raleigh, NC 27614**
**Tel# (919)570-7010 Fax# (919)570-7020**

**Information to be released (please check the appropriate box)**

___Immunization record ___Laboratory results/Xray reports ___Consult Reports ___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
___Continuity of Medical Care
___Coordination of Care

**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).

**Fees for Copying Medical Records**

Your prior health care provider may charges fees for the photocopying of your records. Please call and inquire from previous doctor their fees for this service.

**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**