Wake Gastroenterology

A division of Wake Internal Medicine Consultants, Inc.

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

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

_____ ___/___/_____ _____-_____-_____
Patient Name Date of Birth Social Security Number

Patient Address: _____
Street City State Zip Code

Consisting of: (Check all that apply)

□ Discharge Summary	□ Pathology Reports	□ Emergency Reports
□ History & Physical	□ Laboratory Reports	□ Other _____
□ Progress Notes	□ Radiology Reports	_____
□ Operative Notes	□ ECG/EEG/Cardiac Cath	_____

From the period of _____ to _____.

Release Information to: _____
Name of Company/Agency/Facility/ Person

_____
Address

_____
City/State/Zip Code

For the purpose of: (please check any that apply)

□ Referral to specialist □ Insurance □ Worker's Comp □ Legal Investigation
□ Disability Determination □ Personal □ Continuing Care
□ Change of Doctor (please give reason): _____
□ Other (specify) _____

If we are requesting this Authorization from you for our own use and disclosure or to allow another heath plan to disclose information to us:

- **We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;**
- **You may inspect a copy of the protected health information to be used or disclosed;**
- **You many refuse to sign this Authorization; and**
- **We must provide you with a copy of the signed authorization.**

You have the right to revoke this Authorization at any time, provide that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.
Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

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: _____ Date: _____
Patient's signature

Or by: _____ Date: _____
Patient's Representative

Description of Representative's Authority: _____

_____

*** Please note that there will be a charge for records when requested for personal reasons or permanent transfer.**