WAKE FOREST BAPTIST HEALTH
(NCBH WFUHS WFBMC Lexington Medical Center
Davie Medical Center Wake Forest Baptist Imaging
NCBH Outpatient Endoscopy Center)

AUTHORIZATION *for* USE *or* DISCLOSURE *of* PROTECTED HEALTH INFORMATION

Patient Name _____
Medical Record # _____
Department Name _____
Telephone Number (336) 71__-_____
Date Rec'd _____ Date Sent _____
Copy given to requestor (Date) _____
THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize _____
(Person(s) or class of persons authorized to use/disclose the information)

_____
(Address)

to release to _____
(Person(s) or class of persons authorized to receive the information)

_____
(Address)

Description of information that may be used/disclosed:
(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and /or HIV/AIDS, if applicable.)

❑Medical Information from the most recent visit/admission to include physician notes/summaries and diagnostic results. Specify which department and location _____.

❑Medical Information including physician notes/summaries and diagnostic results for the periods from _____ to _____.

❑Other: Specify information to release_____ for the periods from _____ through _____.

The information will be used/disclosed for the following purposes:

Please specify the reason for this request, e.g. treatment, insurance, legal, etc

_____

_____

□ At the request of the individual

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed or required by law.

I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the WFBH Privacy Office. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization. Information about the right to revoke has been shared with me in the WFBH Notice of Privacy Practices. This authorization expires _____. Unless specified or revoked, this authorization will expire one (1) year from the date signed.

_____ _____
Signature of Patient or Personal Representative (*if applicable*) Patient's Date of Birth

_____ _____/_____
Relationship to Patient Requestor's Home Phone/Work Phone

_____ _____
Authority to Act Date/Time

This release is limited to the department specified at the top of this form.
To obtain information from another department or from Wake Forest Baptist Health) individual authorizations will be needed.
Please contact the specific department or WFBH HIM Department at (336) 716-3230.

MRROI