WAKE PEDIATRIC GASTROENTEROLOGY
Because Children Deserve the Best

Authorization to Release Medical Information

Patient (child's) name: _____

Patient (child's) date of birth: _____

The **person requesting this authorization**: _____

Your relationship to the patient (parent or legal guardian)**:** _____

I, _____, hereby consent to the release and disclose personal health information of the above-mentioned patient to:

Physicians (facility) name:_____ Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

For the following purpose:
□ Referral □ Physician Change/second opinion □ Primary Care Physician
Other reason:_____

Which medical information would you like to be released:
□ All Records □ Information for a specific date of service _____
□ Investigations (labs, procedures, radiology tests, etc)
Other:_____

I understand that the information outlined in this release will be disclosed within 2 weeks after we receive this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

Your name

Signature Date