E. Brooks Wilkins Family Medicine, PA
4020 Wake Forest Road, Suite 201
Raleigh, NC 27609

www.ebwmd.com
Telephone: 919.571.6465
Facsimile: 919.571.6455

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
SSN#: ___ - ___ - _____ Patient's phone #: (___) _____
Date of Request: _____ **Date Needed:** _____

☐ I authorize E. Brooks Wilkins Family Medicine **to release information TO**:	OR	☐ I authorize E. Brooks Wilkins Family Medicine **to obtain information FROM**:
_____ Name of Provider or Facility		_____ Name of Provider or Facility
_____ Address		_____ Address
_____ City, State, Zip Code		_____ City, State, Zip Code
(___) _____ Phone #/ (___) _____ Fax #		(___) _____ Phone # (___) _____ Fax #

PURPOSE FOR THIS REQUEST: (Check one.)
□ Continuing Healthcare / Referral to Specialist □ Personal □ Insurance □ Transfer of Care / Change of Doctor
□ Other (Please Specify) _____

TYPE OF RECORDS REQUESTED: (Check all that apply.)
□ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
□ Specific information (Select one or more, as applicable)

□ Immunization History □ History & Physical □ Radiology Reports
□ Progress Notes □ Laboratory Reports □ Other _____
□ ECG/Stress Tests □ Operative Notes _____
□ Records Related to a specific Illness or injury _____
Illness / Injury *Date(s) of Treatment*
□ Records from _____ to _____
□ Billing and Insurance Information
□ Entire Copy of E. Brooks Wilkins Family Medicine, PA Record

_____**I do** _____ **I do NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse. **(Please Initial)**

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, nor will it affect my eligibility for benefits.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by HIPAA privacy regulations, the information stated above could be redisclosed.
- There may be a charge for the requested records from the originating office.
- Records requested from EWBFM for personal use will be left at the front desk for the patient to pick up. Medical records will be faxed only in cases of medical necessity, and only to health care or medical insurance providers.
- I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)* _____