WAKE FOREST BAPTIST HEALTH
For a list of entities covered by this form please see
www.wakehealth.edu/compliance/Notice-of-Privacy-Practices.htm.

For Office Use Only: MRN: _____
Date Rec'd _____ Date Sent _____
Copy given to requestor (Date) _____

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

THIS FORM MUST BE COMPLETED IN FULL

I consent to and authorize release of the health information of: _____
(patient name & date of birth)

To be Released From/By: _____
(Name of Health Facility, Practice or Department authorized to use/disclose the information)

_____
(Address or location of Facility, Practice, Department who may use/disclose the information)

To be Released to: _____Brenner Children's Developmental and Behavioral Pediatrics
(Name of Entity, Person(s) or class of persons authorized to receive the information)

_3325 Silas Creek Pkwy.
(Address of authorized recipient of information)

_____Winston-Salem, NC 27103 336-713-0678 336-713-7842
(City/State/Zip) Phone Number Fax Number

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.)*

Specific records:

- ❑ Emergency Department
- ❑ Discharge Summary
- ❑ History & Physical
- ❑ Operative Report
- ❑ Office/Clinic Note
- ❑ Radiology result
- ❑ Cardiac Catheterization
- ❑ Pathology report
- ❑ Lab result
- ☒ Other specific (please list): _Developmental Evaluation_____
- ❑ Entire visit (provider notes, results, flowsheets/nursing notes, scanned documents, etc.)

Must provide the **treatment/visit date(s):** ❑ most recent or specific date range ❑ _____ to _____

Please provide the **treatment location** (specific hospital, or physician practice location, department): _____

The information will be used/disclosed for the following **purpose:**

□ At the request of the individual □ treatment □ insurance □ legal □ changing doctors □ Other: _____

Requested format: ❑ Electronic Copy ❑ Paper copy ❑ CD ❑ Other_____ *(if not specified, records will be provided in paper form)*

Delivery method: US mail unless otherwise requested as: ❑pickup ❑MyChart (if available, appropriate) ❑ Other: _____

- I understand that if the person(s) 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 based on this authorization. Information about the right to revoke has been shared with me in the WFBH Notice of Privacy Practices. This authorization expires on _____. Unless a date of expiration is provided or this authorization is revoked, this authorization will expire one (1) year from the date signed.

_____ _____
Signature of Patient or Personal Representative (*if applicable*) **Date/Time**

_____
Relationship to Patient (if other than Patient authorizing)/Authority to Sign if other than patient
(written proof may be required)

This release is limited to the Facility/Practice or Department **you specified above.**

To obtain information from another Facility/Practice or Department individual authorizations will be needed.

MRROI