

Wake Internal Medicine Consultants, Inc. 919.781.7500



Authorization to Release Medical Records to Wake Internal Medicine/or its divisions

authorize:		
	Name of Company/Agency/Facility/ Person	
Address:		
City/State/Zip:		

To release a copy of the specific health and medical information described below:

	Patient name		<u>XXX</u> I Security Number		
ldress:		City/State/Zip Code:	City/State/Zip Code:		
tient P	hone #				
onsi	sting of:				
Last	2 years of records <u>OR</u>		_		
	□ Most recent history &	□ Most recent EKG/2D Echo/	□ 2 most recent DEXA scar		
	physical /consult	Stress Echo/Carotid	Most recent Mammogram		
	reports/hospital history &		□ Most recent		
	physical/discharge	ABI's/Angiograms/cardiac catheterization	colonoscopy/path Given Most recent EGD/path		
	summary Most recent Laboratory	□ Pulmonary Function Test	□ Wost recent EGD/path □ Vaccination Record		
	Reports	□ X-ray/CT/Ultrasound/MRI	\Box Other		
	Reports	reports			
	Release Information to: Wake	Internal Medicine Consultants, Inc.			
	3100 Blue Ridge Rd., Ste. 300 Raleigh, NC 27612 Phone: 919-781-7500 *Fax Ste. 300: 919-881-9586 Attn:	Raleigh, Phone: 9 *Fax: 919	 10880 Durant Rd., Ste. 100 Raleigh, NC 27614 Phone: 919-781-7500 *Fax: 919-420-6065 Attn: 		
* If	more than 20 pages, please mail				
Ee.	the purpose of:				
$\Box R$	eferral to specialist □ Insur hange of Primary Care Doctor □	ance Personal Copy Other (specify)			
I here signa notific of fac	hange of Primary Care Doctor		ion is valid for 180 days from the date ot affect any information released prior disclosure by the person or class of person that the medical provider to whom this zation. I understand that this includes th		
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Or By: _____ Date: _____ Date:

* Please note that there may be a charge from the facility providing records