



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name _____

Date of Birth _____

Daytime Telephone Number _____

I HEREBY AUTHORIZE:

**Wake Orthopaedic, LLC
3009 New Bern Ave.
Raleigh, NC 27610
919-232-5020 Telephone
919-232-5021 Fax**

To Release Information To:

Name of Person or Organization Releasing Information

Street Address

Phone Number

City, State, Zip Code

Fax Number

This Release Includes: (Please Check Box for Requested Records)

All Records Date of Service _____

Lab X-Ray Reports

Other: _____

This authorization shall be valid until written notice is received. Please indicate a date after which no information can be released. If no date is given, consent will be valid for 90 days only. I further understand that I have a right to receive a copy of this authorization upon request.

Patients Signature

Date: _____

Parent, Guardian or Authorized Representative

Date: _____