WAKE ORTHOPAEDICS

3009 New Bern Ave
Raleigh, NC 27610
919-232-5020
919-232-5021 Fax

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name _____

Date of Birth _____Soc. Security No._____

Daytime Telephone Number _____

I HEREBY AUTHORIZE:

Wake Orthopaedics
3009 New Bern Ave
Raleigh, NC 27610
919-232-5020
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.

_____ Date: _____
Patients Signature

_____ Date: _____
Parent, Guardian or Authorized Representative