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MEDICAL RELEASE OF INFORMATION FORM

ALL INFORMATION REQUIRED. PLEASE FILL IN ALL REQUESTED INFORMATION.

Patient Name: _____ Date of Birth: _____

I request and authorize _____
[Name of physician and clinic/practice]

Address/City/State/Zip _____

Phone: _____ Fax: _____

To release the medical record of the above-named patient to:

Name of recipient: _____

Address/City/State/Zip _____

Reason for release: _____

This request and authorization applies to: *Please initial next to the appropriate line. (Please initial only one)*

_____ ALL HEALTHCARE INFORMATION including immunization records, well and sick visits, labs, x-ray reports.
NOTE: There is a fee of \$25.00 for the first child and a fee of \$10.00 for each additional child.

_____ MOST RECENT HEALTHCARE INFORMATION including immunization records, last physical exam with labs.
NOTE: There is a fee of \$5.00 for each child

Please initial the following acknowledgement:

_____ I understand I have the right to revoke this authorization by providing a written request to do so to the above-named physician or organization. I understand that the revocation will not apply to information that has already been released.

_____ [Signature of patient or authorized representative.] _____ [Date.]

_____ [Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)]

Unless otherwise revoked, this Authorization will expire SIX (6) MONTHS from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

PLEASE ALLOW TEN (10) TO FOURTEEN (14) BUSINESS DAYS TO PROCESS YOUR REQUEST.