Wake Forest University Deacon Health
PO Box 7386 Winston-Salem, North Carolina 27109
336-758-5218 FAX 336-758-6054

MEDICAL RECORD INFORMATION RELEASE FORM

Name of Individual: _____

WFU ID#: _____ Birth Date: _____ Cell number:_____

I am requesting WFU Deacon Health

☐ Release records TO: ☐ Obtain records FROM:

Name/ Office: _____

Address: _____

City/ State/ Zip: _____

Phone: _____ Fax: _____

Email is not a secure form of transmission. Records will be mailed/ faxed

Fill in dates of treatment for records to be released: From: _____ To: _____

Please select the following records to be released and/ or obtained:

- ☐ Assessment/ Diagnosis
- ☐ Hospital Records
- ☐ Immunization Records
- ☐ Laboratory Records
- ☐ Medications
- ☐ Mental Health/ Psychiatry
- ☐ Treatment Summary/ Recommendations
- ☐ Other _____

HIV, Mental Health and Drug and Alcohol information in the parts of the record indicated above will be released through this authorization unless stated otherwise.

Please select the following records that you do not want to be released. Do <u>not</u> release:

- ☐ Drug and Alcohol Use
- ☐ HIV testing
- ☐ Mental Health/ Psychiatry

Select reason for the release and/ or obtaining the date range of services:

- ☐ Continue/ Coordination of Care
- ☐ Referral
- ☐ Accommodation Considerations
- ☐ Departing WFU
- ☐ Other _____

This authorization of release pertains only to the above specified information and to the above specified parties. I also understand that I may revoke this authorization at any time in writing. The revocation will not apply to information that has already been released.

Signature: _____ Date: _____

Date Sent/ Given: _____ By Whom: _____

Allow 2 business days for records to be copied and sent.