WILSON OB-GYN

2500 Horton Boulevard • P.O. Box 7639 • Wilson, North Carolina 27893 • 252 206-1000
Fax # (252) 237-0704 Email: Melissa.Webb@uwhcarolinas.com

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
SS# _____ Patient's phone#: ( ) _____
Date of Request: _____ Date Needed: _____

□ I authorize Wilson Ob-Gyn **to release information to:**	OR	□ I authorize Wilson Ob-Gyn **to obtain information from:**
_____ Name of Provider or Facility		_____ Name of Provider or Facility
_____ Address		_____ Address
_____ City, State, Zip Code		_____ City, State, Zip Code
_____ Phone #/Fax # (include area code)		_____ Phone #/Fax # (include area code)

TYPE OF RECORDS REQUESTED: (Check one) □ All Records □ Date of Service _____ to _____
□ Other _____
_____

EXPIRATION DATE OF AUTHORIZATION: This authorization is effective through ____/____/_____ unless revoked or terminated by the patient or the patient's personal representative.

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION: You may revoke this authorization at any time by submitting a written request to the address above.

POTENTIAL FOR RE-DISCLOSURE: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Relationship to Patient (if requester is not the patient)

Date Completed: _____ Completed by: _____
Total Pages: _____ Sent via: Mail Courier Certified Mail Fax Picked-Up
Fax Number: _____