

Women's Health Alliance, P.A. pka
WILKERSON OBSTETRICS & GYNECOLOGY

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AUTHORIZATION FOR RECORDS RELEASE TO WILKERSON OB/GYN

(Print Patient's Full Name) Birth Date (Mo/Day/Yr) _____

(Street Address) Social Security Number _____

(City, State, Zip Code) Phone (Home) _____

At the request of the individual, I _____, do hereby authorize
(Patient's Name)

_____ to release:
(Name/Address/Telephone Number of Doctor/Facility)

_____ Complete Medical Records
_____ Records of Care from _____ to _____ only
_____ Other (Please specify) _____

_____ I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: WHA pka Wilkerson Obstetrics & Gynecology
4414 Lake Boone Trail, Suite 210
Raleigh, NC 27607
919-571-1040 Fax 919-781-0247

REASON for RELEASE:
_____ REFERRAL TO SPECIALIST _____ INSURANCE _____ WORKERS COMP _____ CHANGE OF DOCTOR
_____ LEGAL INVESTIGATION _____ DISABILITY DETERMINATION _____ PERSONAL _____ MOVING
OTHER (SPECIFY) _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of Patient _____ **Date** _____

Witness