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

MEDICAL RECORD INFORMATION RELEASE FORM

I. Name of Individual: _____
(Last) (First) (Middle)

2. WFU ID #:_____ Birth Date: _____ _____ _____ Cell Number: _____
MO DAY YR

3. Circle A or B.

A. **Allow 2 business days for records to be copied**. I request that the WFU Deacon Health release information, with the stipulation that the released information be kept confidential, to:

Provide address where records can be mailed if not picked up within 5 days:

_____
(Name)
_____
(Address)
_____
(City) (State) (Zip)

B. I request that information be released **to** WFU Deacon Health from:

_____
(Name)
_____
(Address)
_____
(City) (State) (Zip)

4. Describe portion of record or specific information to be released: _____

_____

HIV, Mental Health and Drug and Alcohol information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated. Do not release:
_____ HIV testing (initials) **_____ Mental Health (Psychiatric) (initials)** **_____ Drug & Alcohol (initials)**

5. Reason for release of information: _____

_____

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. This authorization will remain valid until revoked or upon expiration of one year from the date of this signed release.

Signature: _____
Date: _____

Witness: _____

Date Sent/Given: _____
By Whom: _____