

**Wilmington Health Associates
Carolina OB/GYN
The Children's Clinic**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that this authorization is voluntary and made to confirm my wishes. I understand that Wilmington Health Associates, Carolina OB/GYN, and The Children's Clinic will not condition treatment on whether I sign this authorization. I understand that information disclosed to my family/friends may be redisclosed by them.

I understand that I may revoke or change this authorization at any time by giving written notice of my revocation to the Contact Office listed below, but that it will not affect any information released prior to notification of revocation.

Section A: Patient Information

Account# _____

Name _____ Phone _____

Address _____ Birthdate _____

City _____ State _____ Zip _____ SSN _____

Section B: Medical Information to be Used or Disclosed

I give permission for you to discuss my medical information with the following family/friends:

I give permission for the following medical information to be discussed:

CHOOSE ONLY ONE:

- All medical information
 Specific information _____

Section C: Expiration

This authorization will expire:

CHOOSE ONLY ONE:

- Two years after death
 18th Birthday (minors only)
 Other _____

Section D: Phone

I give permission for you to leave medical information regarding my care or appointments on the following answering machine: (_____) _____ - _____

I acknowledge that I have received Wilmington Health Associates, Carolina OB/GYN and The Children's Clinic Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this notice.

Signature of Patient

Signature of Personal Representative

Date

Relationship to Patient

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Contact Office: WHA Privacy Officer, 1202 Medical Center Drive, Wilmington, NC 28401
Telephone: 910-796-7701 Fax: 910-341-3449 Email: privacy@wilmingtonhealth.com