Wake Endoscopy Center, LLC
Raleigh Medical Group Gastroenterology
(A Division of Raleigh Medical Group, P.A.)
2601 E. Lake Drive, Ste 201
Raleigh, NC 27607
Phone (919) 783-4888 Fax (919) 783-4887

Authorization for Release of Medical Information

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

_____ _____
Address Phone (Home)

_____ _____
City/State/Zip Code Phone (Other)

To ____ From _____ _____
(Facility Name)

_____
(Address)

_____

I hereby authorize and request you to release to _____ from _____
Wake Endoscopy Center, LLC
Raleigh Medical Group Gastroenterology
2601 E. Lake Dr., Ste 201
Raleigh, NC 27607
Fax: (919) 783-4887

Release (Check all that apply):

All Records _____ Specific Dates _____
Diagnostic Records _____
Billing Records _____

Is this a permanent transfer? Yes _____ No_____
Reason for request _____

_____ _____
Signature (full name) of patient, legal guardian, if under 18 or POA Date

_____ _____
Witness Date

This authorization will expire 180 days from date executed unless otherwise specified.

All requests will be processed within 10 business days of the date of the request. We will make every effort to accommodate special requests but this is not always possible. There may be a fee associated with processing any request for medical records. Please contact our medical records department for further information.