CONSENT AND ACKNOWLEDGEMENT FOR DISCLOSURE AND/OR REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Wake Forest Baptist Imaging

265 Executive Park Blvd Winston Salem, NC 27103

Patient Name:	Date of Birth:	MR#:
Address:	Phone #:	SS#:
City:	State:	Zip Code:
Consent & Acknowledgem	nent	
reports and labs associated w physician or other physicians	physicians or individuals you wish to ex	ns to my insurance carrier, referring oppy of this authorization to be used in place
results, or my patient informaccount. As a patient of WF	g has permission to call and leave a meation on the voice mail or answering managers. I acknowledge that I had the opported by HIPAA. I understand I may reque	achine for the numbers listed on this tunity to review the WFBI Notice of
authorization, I must do so in understand that the revocation	on will not apply to my insurance comper my policy. <i>Unless revoked, this auth</i>	evocation to WFBI Attn: Administrator. I any when the law provides my insurer
_	the disclosure of health information is the this form in order to assure treatment	
Signature *If patient is minor, responsible party must	t sign	Date
DO NOT release my medica	al information to:	
	may need another individual (family or othe s name, DOB and relationship below.	r) to pick up your medical images and/or
Name:	Relationship:	Date of Birth:
Signature:	Date:	