
Release of Medical Records

I give Wake Family Medicine and its staff permission to release information regarding my medical condition and treatment such as lab reports, test results, medication, diagnosis, prescriptions, medical records, etc to the persons listed below. I understand that if I want to make any changes regarding release of my information, I must notify Wake Family Medicine and its staff in writing.

Name	Relationship to Patient
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Signature of Patient

Date

Signature of Parent/Guardian if Patient is a Minor

Date

Signature of Staff Member

Date