Wake Forest Endoscopy Center

10540 Ligon Mill Rd., Suite 109
Wake Forest, NC 27587

Chart # _____ Date _____

I give my permission for the providers of the Wake Forest Endoscopy Center to release ANY information about my medical condition, prescriptions, and financial account to:

Name: _____
Name: _____
Name: _____

Below, I give my, permission for the providers of the Wake Forest Endoscopy Center to release prescriptions and samples ONLY to:

Name: _____
Name: _____
Name: _____

The above mentioned person (s) will be required to provide photo ID when picking up requested items.

Patient name: _____ DOB: _____

Patient signature: _____

By signing on the line below, I acknowledge that 1 was provided access to Privacy Practices of the Wake Forest Endoscopy Center:

Print Name: _____ DOB: _____

Patient Signature: _____

For Personal Representation of the patient (if applicable)
Print Name of Personal Representative: _____
Representative's Relationship (i.e. parent/guardian/other, etc.): _____
Signature of Personal Representative: _____

_____ I refuse to acknowledge I was provided access to the Notice of Privacy Practices of Wake Forest Endoscopy Center:

_____ _____
Signature of Practice Employee Date