Garner Internal Medicine **Chart #____________**

200 Health Park Drive #100, Garner NC 27529

(919) 773-1223 Fax (919) 773-1955

Authorization for Release of Medical Information

Patient Name: ____Date of Birth: ______________________________

Address, City, State, ZIP: ____

Phone: (___) ______________________________

Please **Obtain** information from:

____
Name of Provider/Clinic

____
Address

____
City, State, Zip

Phone: Fax:

Please **Send** information to:

____
Name of Provider/Clinic

____
Address

____
City, State, Zip

Phone: Fax:

Specify date(s) of records to be sent:____

Put your **initials** next to the specific records that apply to your request:
______ Clinical Notes ______ Radiology Reports _____Lab and Pathology Reports ______Hospital Notes

______Genetic testing _____ EKG ______Specialist Consult Notes ______ HIV/AIDS/other infectious diseases

______Mental Health notes _______ Drug and Alcohol ______Other____

Put a **checkmark** next to the purpose of the request:
_____ Continued Patient Care _____Social Service/Disability _____Insurance _____Attorney/Legal

_____Worker's Compensation _____Personal _____Other____

Put a **checkmark** next to how you would like your records sent:
_____Mail to address above _____Faxed to # listed above _____Pick up at office

I understand that I may revoke this authorization at any time; the revocation will not apply to information that has already been released in response to this authorization. I must revoke this authorization in writing. My treatment cannot be conditioned upon signing this authorization and I have the right to refuse to sign.
A fee may be charged for copying the protected health information. Please contact Garner Internal Medicine to obtain fee information at 919-773-1223.
I have been informed and understand that information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed the privacy information may no longer be protected under federal HIPAA privacy laws.

Unless otherwise revoked, this authorization will expire on the following date or event: ________________________________.
If I fail to specify an expiration date or event, this authorization will expire automatically in ninety (90) days from the date of signature.

I have read and understand the information in this authorization form.

Signature of Patient or Authorized Representative: ____

Print Patients name: ____Date:__________________

Office use only: Processed Date: ________________________Processed by: ________________________ (6/13)