

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Important-Please mail records if over 10 pages



I authorize: (Check One)

Name of Person or Facility:		
Address, City, State, ZIP:		
Phone:	Fax:	Email:

To use or disclose to:

Name of Person or Facility: Garner Family Practice		
Address, City, State, ZIP: 801 Poole Drive, Garner, NC 27529		
Phone: (919) 779-1440	Fax: (919) 662-0613	Email:

The MEDICAL RECORD (Protected Health Information) OF:

Patient Name:		Date of Birth:
Address, City, State, ZIP:		
Phone:	Medical Record #:	SSN (last four):
Treatment Dates From: _____ to _____		

Put a CHECKMARK next to the specific documents that apply to your request:

<input type="checkbox"/> Clinic Notes	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Nurses Notes	<input type="checkbox"/> Emergency Room
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Urgent Care	<input type="checkbox"/> Doctor Consults
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Other
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Physician Orders	<input type="checkbox"/> EKG, EEG, EMG	

Place your **initials** in the applicable boxes below to authorize the release of **SENSITIVE** information pertaining to:

<input type="checkbox"/> Mental Health	<input type="checkbox"/> Drugs & Alcohol	<input type="checkbox"/> HIV/AIDS/ other infectious diseases	<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> Not Applicable: None of these apply
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Put a CHECKMARK next to the purpose of the request:

<input type="checkbox"/> Continued Patient Care	<input type="checkbox"/> Social Service / Disability	<input type="checkbox"/> Insurance	<input type="checkbox"/> Other:
<input type="checkbox"/> Personal	<input type="checkbox"/> Attorney / Legal	<input type="checkbox"/> Worker's Compensation	

Put a CHECKMARK next to how you would like to receive your request:

<input type="checkbox"/> Mail to address above.	<input type="checkbox"/> E-Mail	<input type="checkbox"/> Verbal	<input type="checkbox"/> Fax to # listed above (Urgent or Prioritized)	<input type="checkbox"/> Pick up at Practice
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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. The procedure for revoking this Authorization is to present my written revocation to the UNC Physicians Network.
- I may refuse to sign this Authorization:
 - My treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned upon my authorization of this disclosure.
 - A fee may be charged for copying the protected health information. Please see the Practice Manger for information.

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 of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date or event or condition, 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:	
Printed Name:	Date:
Signature of Authorized Representative:	
Printed Name:	Date:
Please explain Representative's authority to act on the behalf of the Patient:	
OFFICE USE ONLY	
Processed Date: _____ Processed By: _____	Stamps / Additional Notes: