Patient Number:_____

Garner Internal Medicine
200 Health Park Drive, Suite 100,
Garner, NC 27529
Phone: 919-773-1223
Fax: 919-773-1955

Authorization for Disclosure of Health Information

All sections must be completed and legible in order for request to be processed

Patient Information:

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

Release Records From: ☐ **Garner Internal Medicine**

Name/Facility: _____ Phone Number: _____
Address: _____ Fax Number: _____
City: _____ State: _____ Zip: _____

Release Records To: ☐ **Garner Internal Medicine**

Name/Facility: _____ Phone Number: _____
Address: _____ Fax Number: _____
City: _____ State: _____ Zip: _____

Information To Be Released: *Please check each item to be released

___ Clinical Notes ___ Radiology Reports ___ Labs/Pathology Reports ___ EKG ___ Immunizations
___ Hospital Notes ___ Specialist Consult Notes ___ Other: _____

Dates of Records to be Released:

_____ to _____.
****Records requested for dates prior to 2011 will incur an additional fee.**

___ Past 3 Months ___ Past 6 Months
___ Past Year ___ Past 2 Years
___ Past 5 Years

Reason for Request:

___ Continued Patient Care ___ Social Service/Disability ___ Insurance
___ Attorney/Legal ___ Workman's Compensation ___ Personal ___ Other: _____

How would you like your records sent:

___ Mail to address above ___ Fax to # above ___ Pick up in office

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I understand that I may cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether I sign this authorization or not. Upon receipt of requested medical records to our facility, Garner Internal Medicine will continue to protect the information under federal law.
A fee may be charged for copying the protected health information. Please contact Garner Internal Medicine to obtain fee information at 919-773-1223.
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 ninety (90) days from the date of signature.
- I have read and understand the information in this authorization form.

Patient's Printed Name: _____ Patient's Signature: _____

Patient Representative & Relation: _____ Date: _____

Office Use Only Processed by: _____ Date: _____