GARNER RHEUMATOLOGY
& INFUSION CENTER

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Information		
Patient Name:	Date of Birth:	Sex: ☐ Male ☐ Female
Address:		
City:	State:	Zip Code:

I authorize the use or disclosure of the above-named individual's health information as described below, by Garner Rheumatology and Infusion Center, PLLC.

The type and amount of information to be used or disclosed is as follows:

☐ Complete health records	☐ most recent laboratory reports
☐ Immunization record	☐ most recent history & physical / consult reports / hospital history
☐ last 2 years of health records	☐ most recent EKG/2D Echo / Stress Echo / Carotid Doppler
☐ most recent medical exams	☐ most recent ABI's/Angiograms/cardiac catheterization
☐ most x-ray / ultrasound / MRI	☐ most recent EGD/path
☐ Pulmonary Function Test	☐ most recent colonoscopy/path
☐ Other	

This information may be disclosed to and used by the following individual or organization:

Releasing Entity		
Name of Company / Agency / Facility / Practice / Person:		
Address:		
City:	State:	Zip Code:

For the purpose of: ☐ Referral to Specialist ☐ Insurance ☐ Worker's Comp ☐ Legal ☐ Disability Determination ☐ Personal Copy ☐ Specialty Office ☐ Change of Primary Care Doctor ☐ Change of Specialty Care Doctor
☐ Other:____

I hereby authorize disclosure of the health information of the above named patient. This authorization is valid for 180 days from the date of signature. 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 of 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 or not I sign the authorization. I understand that this includes the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency). I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Patient or Representative Signature: ____ Date: ______________________

Patient or Representative Name: ____

Description of Representative's Authority: _______________________________________

*Please note there will be a charge for providing copies when transferring or for personal use.