GARNER RHEUMATOLOGY
& INFUSION CENTER

810 Timber Drive, Garner, NC 27529 • Tel 919-747-9040 • Fax 1-833-450-7300
www.garnerrheumatology.com

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:

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

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:

Garner Rheumatology and Infusion Center, PLLC
810 Timber Drive
Garner, NC 27529
Tel 919-747-9040 • Fax 1-833-450-7300

For the purpose of: ☐ Referral to Specialist ☐ Insurance ☐ 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: _____