

Authorization for RELEASE of Information

I hereby allow Dr. Lisa A Garner to disclose my protected health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization.

I understand that my records may be subject to disclosure by the recipient, and may no longer be protected by federal privacy regulations.

Print Patient Name _____

Date of Birth _____

I authorize you to release the following protected health information to:

Name of physician/facility/entity _____

Street Address _____

City, State, Zip _____

Phone Number _____

Fax Number _____

From the health records of: Dr. Lisa A Garner

Check all protected health information that may be released:

- | | | |
|--|--|--|
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Path Reports | <input type="checkbox"/> Medical History |
| <input type="checkbox"/> Patient Notes | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Visit Notes | <input type="checkbox"/> Procedure Reports | |

Dates may range:

From: _____

To: _____

Purpose of disclosure:

- | | | |
|---------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Attorney | <input type="checkbox"/> At the request of the patient |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Other _____ | |

I understand that this authorization will expire by law 180 days from the date of this authorization.

Signature of Patient or Patient's Representative

Date