Lisa A. Garner MD, PA
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____SS#_____ DOB: _____

authorize_____ to release the following medical

information to: □ Lisa A. Garner, MD, PA and associates
□ Myself
□ Other _____

(Please initial appropriate line below)

_____ All of my medical records (as of the date of this release)

_____ All of my medical records **except** the following: _____

This release also specifically allows the release of the following information (this information will not be released unless the appropriate box is initialed):

☐ Any record of testing, treatment, reporting or research pertaining to infection with HIV, any sexually transmitted or related disease.

This release is effective for an unlimited duration while I am a patient in this practice, unless revoked by me by providing notice in writing to the above named party. I acknowledge receiving a completed copy of this release.

A copy of this form is acceptable authorization for the release of the above described information.

S/_____ Date_____
Patient/Legal Representative (parent or legal guardian)
Relationship to Patient _____

S/_____
Witness

This release authority is prepared pursuant to the requirements and applies to any information governed by of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et seq., and regulations there under, as amended from time to time, collectively referred to as "HIPAA"and Patient Protection and Affordable Care Act of 2010 (ACA 2010) built on HIPAA 1996. Modification to the HIPAA Privacy, Security Enforcement, and Breach Notification Rules under the Health Information and Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; other Modifications to the HIPAA Rules. [Document 78 FR 5565, pages 5565-5702, 45 CFR 160, 45 CFR 164, RIN 0945-AA03, Document 2013-01073] and all other applicable state and federal law.