_____ **AUTH**

ACCOUNT NUMBER

FOR OFFICE USE ONLY
Verified Photo ID
(Initial) _____

Authorization For Release Of Patient Information From

GRAVES GILBERT CLINIC

Request is made for information concerning the care of:
Patient's Name (PLEASE PRINT) _____
Patient's DATE OF BIRTH _____
Patient's SOCIAL SECURITY NUMBER _____
Patient's TELEPHONE NUMBER _____

The following documents are to be released: (check all applicable)
_____ EKG Reports _____ Lab Reports _____ Immunization Records
_____ X-ray Reports _____ All notes contained in the clinical chart
Notes compiled between the dates of _____ and _____
Notes prepared by or for Dr. _____ and his/her practice partners

___Instead of documents I authorize the disclosure through oral communication of impressions and all other health information

Copies of information checked above should be sent to, or orally disclosed to:
Name: _____ Phone Number: _____
Address: _____
(Circle Disclosure Method) Hold for pick up Mail Fax to: _____

The purpose for requesting this release of information is (check one):
_____ At the request of the individual
_____ Other (please describe) _____

Your authorization is revocable. Our Privacy Notice contains details of how to revoke your authorization. Unless so revoked, this authorization shall remain valid until: (check one)
_____ The 60th day after the date appearing next to the signature below
_____ Other (please specify date or event) _____

The willingness of the Graves-Gilbert Clinic to treat you as a patient is not dependent upon or conditioned on you signing this authorization. Please note that information disclosed to others may be subject to further disclosure by those individuals, any may no longer be protected by federal HIPAA rules.

I the undersigned hereby authorizes the Graves-Gilbert clinic, its shareholders, employees and agents to disclose, reveal or open for observation or inspection to the individual or entity whose name appears above, the records or reports described above.

If the individual signing this release is representative of the patient, or one holding themselves out as a representative of the patient, then the individual signing this authorization agrees to indemnify the Graves-Gilbert Clinic, and its employees and agents for any losses resulting from the release of information made in reliance on this authorization.

_____ I intend on returning to the Graves-Gilbert Clinic for care.
_____ I *do not* intend to return to the Graves-Gilbert Clinic for care, please inactivate my chart.

Signature _____ Date _____ Relationship if signed by representative _____

Please e-mail or fax a copy of your photo ID to medicalrecords@ggclinic.com
Medical Records Fax # (270) 783-3741