



GRINER MEDICAL GROUP

Quality Healthcare For All Ages

3301 N. OAK ST. EXT
VALDOSTA, GA 31602

Phone (229) 242-6061 Fax (229) 242-6151

HIPAA Authorization for Release of Protected Health Information Form

Date _____ Date of Birth _____

First Name _____ Middle Name _____ Last Name _____

Address _____

(City, St, Zip) _____

Home Number _____ Work Number _____ Cell Number _____

I authorize the release of my Protected Health Information voluntarily by the Person(s) named below:

PHI requested from: Brian C Griner MD

Address, City, State: 3301 N. Oak St. Ext.

Phone Number: 229.242.6061 Fax Number: 229.242.6151

PHI may be released to: _____

Address, City, State: _____

Phone Number: _____ Fax Number: _____

Receipt of Records: **CHECK ONE** Pick Up: Mail: Fax:

Purpose for releasing protected health information (Please choose one).

Transferring Physician Other: _____

Referral for Continued Medical Care _____

Legal Action (please specify) _____

Insurance Requirements _____

Moving (provide date of move) _____

Insurance Information

Primary: _____ Secondary: _____

Have you previously been a patient of Dr. Griner's? (Please circle one) YES or NO

Reason for leaving: _____ Date: _____

Signature of Authorizing Party _____ Date: _____

Print Signature _____

Relationship to Patient _____

Witness Signature _____ Date: _____

In Office Only:

Dr. Griner:

Accepted _____ Declined _____

Comments: _____

Payment Received By: _____

Circle Method of Payment: Cash Check Credit Card

Check or CC Trans #: _____