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:_____

Address, City, State**:**_____

Phone Number:_____Fax Number:_____

PHI maybe released to: **Brian C Griner MD**

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

Phone Number:**229.242.6061** Fax Number:**229.242.6151**

Receipt of Records: Pick Up: _____Mail:_____ Fax: _____

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

_____Transferring Physician
_____Referral for Continued Medical Care
_____Legal Action
_____Insurance Requirements
_____Moving (provide date of move)_____

Other:_____
_____
(please specify)

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 #: _____