

Garner Family Practice, P.A.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Garner Family Practice:

- to file insurance claims for all services provided to me and I authorize payment for those services to be made directly to the provider;
- to release information about me to any referring physician or other provider or to any institution or provider as necessary to provide treatment or diagnosis for me;
- and my physician or other provider(s) to release information about me as necessary to process claims for payment for services provided to me, including to health and liability insurance companies, agencies processing Medicare, Medicaid, or workers' compensation claims; medical benefit plans, case managers or reviewers; third parties responsible for paying claims for services provided to me.

This authorization may be revoked at any time except to the extent that action based upon it already has been taken. This authorization expires one (1) year from this date, except as disclosure is necessary after that date to process financial claims or is permitted by law. I understand that this authorization covers services I may receive today or within twelve (12) months from today.

I release Garner Family Practice, P.A., its employees and physicians from any legal liability for disclosure authorized herein.

If I have questions about this authorization or change my mind, I understand that I may contact Julia B. Wall, Practice Administrator.

Patient/Patient Representative Signature

PRINT Patient/Patient Representative's Name

Today's Date

If Patient Representative signs: I confirm that I am legally authorized to speak in the patient's behalf regarding disclosure of information about this patient.

Patient Representative Signature

Relationship to Patient

Today's Date