For pediatric patients please include a current shot record.

B R I A N G R I N E R M.D. L.L.C.
117 W. NORTHSIDE DRIVE
VALDOSTA, GA. 31602

HIPPA 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 ____

Address, City, State: ____

Phone Number: ______________________ Fax: ______________________

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 #:__________________