



**For pediatric patients please include a current shot record.**

BRIAN GRINER 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 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: \_\_\_\_\_