Gaston Medical Group, P.A.

660 Summit Crossing Place
Suite 301
Gastonia, NC 28054
Phone 704-867-0735
Fax 704-867-0738

Authorization for Release of Health Information

RECORDS NEEDED ASAP: _____ YES _____ NO DATE OF APPOINTMENT: _____ GMG CHART#: _____

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations.

Print Patient Name: _____
First Middle/Maiden Last

Address: _____
Street City State Zip

Last 4 Digits of Social Security #: _____ Date of Birth: _____ Age: _____

Information to be released **FROM**:

Facility Name: _____

Address: _____
Street

_____
City State Zip

Phone: _____ Fax: _____

Information to be released **TO**:

Facility Name: _____

Address: _____
Street

_____
City State Zip

Phone: _____ Fax: _____

Dates of service being requested: From _____ To _____ or SEND ALL RECORDS _____ YES _____ NO

*** IS PATIENT CHANGING DOCTORS? _____ YES _____ NO

Check the specific information to be released (used or disclosed):

_____ Office Notes _____ Radiology Reports/Imaging/X-rays _____ Laboratory/Pathology Reports _____ EKG/Monitors
_____ Other (specify) _____

Purpose of Disclosure:

_____ Medical Review _____ Legal Review _____ Insurance _____ Personal Use _____ Other: _____

Will the health care provider requesting the authorization receive any financial or in-kind compensation in exchange for using or disclosing the health information described above? _____ Yes _____ No

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and / or human immunodeficiency virus (HIV).

I understand that I have a right to revoke this authorization at any time by notifying the Medical Records Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response tothis authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of the private health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

This authorization is valid 90 days from date of signature.

Printed Name: _____ Signature: _____ Date: _____

Patient/Authorized Representative: _____ Spouse _____ Parent _____ Other: _____

*****Please note, if information relating to the treatment of drug or alcohol abuse is being released for a patient under the age of 18, the patient must also sign this authorization.**

Signature of Minor: _____