CARNETT CLINIC

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Carnett Clinic, LLC to transfer, release, or obtain information on:

_____ _____
PATIENT NAME DATE OF BIRTH

OBTAIN FROM:

_____
PHYSICIAN/INSTITUTION

_____
ADDRESS

_____
CITY, STATE, ZIP

_____
PHONE FAX

SEND OR FAX TO:

_____
PHYSICIAN/INSTITUTION

_____
ADDRESS

_____
CITY, STATE, ZIP

_____
PHONE FAX

FOR THE PURPOSE OF:

_____

PLEASE CHECK SPECIFIC INFORMATION REQUESTED:

_____ ALL MEDICAL RECORDS (to include all listed below except billing records)

_____ BILLING RECORDS _____ MENTAL HEALTH _____ DRUG/ALCOHOL TREATMENT

_____ COMMUNICABLE DISEASE INFO _____ OTHER

This authorization will expire one year from the date of signature. When your information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer by protected by the federal HIPAA Privacy Rule. You have the right to revoke this authorization at any time in writing.

I HAVE READ AND UNDERSTAND THIS AUTHORIZATION:

_____ _____
PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____
WITNESS DATE