GRANGER MEDICAL CLINIC

Authorization to Release Information (ROI)

Granger partners with Verisma to process medical records requests. Records are not processed at clinical locations.

Patient Information		
Name:	Date of Birth:	Phone Number:
Street Address:	City, State, Zip Code:	

Release Information To (Person or Entity #1):			
Name of Person or Organization:			Phone:
Street Address:	City, State, Zip:		
Email:			Fax:
Preferred Record Delivery Format (check appropriate boxes below):	☐Secure Email (preferred)	☐Fax	☐ Mail (Paper Copies)

Release Information To (Person or Entity #2):			
Name of Person or Organization:			Phone:
Street Address:	City, State, Zip:		
Email:			Fax:
Preferred Record Delivery Format (check appropriate boxes):	☐Secure Email (preferred)	☐Fax	☐ Mail (Paper Copies)

Purpose of Request (select one):		
☐Continuity of Care (treatment with another provider)	☐Legal (attorney, court, or litigation-related)	
☐Insurance/Disability Claim	☐Personal Use (patient request)	☐Other: _____

Information to be Released:					
☐All Records	☐Op Reports	☐Procedure Reports	☐Office Visit Notes	☐Lab Results	☐Billing Records
☐Imaging Reports (Written Results)	☐ Radiology Images (X-rays, MRI, etc…)		☐Other_____		

Records Needed (select one):		
☐All Dates	☐Specific Date Range: _____to _____	☐Most Recent Visit Only
☐All Records from Department/Provider: _____		
☐Certified Copy Requested: *A certification of the records will be included with the fulfilled request.*		

Sensitive Information:				
I understand that my medical record may contain sensitive information. Please check any information you do **NOT** want shared.				
☐Substance Use Treatment	☐Behavioral Health	☐Genetic Testing	☐HIV/AIDS	☐STI's

Acknowledgement:

I understand:

- I have the right to inspect and obtain copies of my records (45 CFR 164.524 under the HIPAA Privacy Rule)
- Information disclosed may be subject to re-disclosure and may no longer be protected by federal law
- This authorization is valid for one (1) year from the date signed unless otherwise revoked
- I may revoke this authorization at any time in writing by contacting: Compliance@GrangerMedical.com
- Revocation does not apply to information already released

Signature and Consent:

By signing below, I authorize the release of my medical records as described above.

Signature: _____ Date: _____

Please return completed documents to MedRecRequest@grangermedical.com

ROI Revised 4.16.2026

This form is used when releasing records outside of Granger.