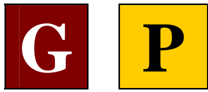

GWINNETT PEDIATRICS AND ADOLESCENT MEDICINE

Release of Medical Information

	Main Office	
3540 Duluth Park Lane	601-A Professional Drive	2089 Teron Trace.
Suite 150	Suite 370	Suite 100
Duluth, GA 30096	Lawrenceville, GA 30046	Dacula, GA 30019
Fax #: 770-476-0947	Fax #: 770-995-7018	Fax #: 770-831-7285

Telephone: 770-995-0823

I hereby request and authorize Gwinnett Pediatrics to use and disclose protected health information ("(PHI)") for the following child(ren) listed below:

Patient's Full Name: ______________________________ Patient's Date of Birth: ________________

Patient's Full Name: ______________________________ Patient's Date of Birth: ________________

Home Phone #___________________________ Cell or Other Phone ___________________________

Current Address ___________________________________ City/State/Zip________________________

This Authorization applies to the following date(s) of service:____________________________________

Complete Medical Records ($10.00 per Child)
Patient Summary of all visits
Immunizations Only
Radiology/ EKG/ Lab Reports

Chart Notes
Consultation Notes
Other:_________________________________

**Medical Records Fee must be paid before the records are printed.

** Reason for Request to Release Complete Medical Records:*
Review by Specialist, Surgeon, or Therapist   Moving From Area   Other (Please specify):

Please release the requested records to:

From To
Gwinnett Pediatrics
(Select Address Above)

Please release the requested records:
From To
Practice Name ____

Address: ____

____

Phone: ____________________Fax:____________________

* Records that contain more than 10 pages will not be faxed for the safety of patient privacy.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. I further understand that this Authorization is specific to the information checked above, for the date(s) of service indicated, and for the purpose written above. Gwinnett Pediatrics and Adolescent Medicine shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams).

______________________________	__________________________	______________
Signature of Patient or Legal Guardian	Printed Name of Signing Party	Today's Date

Relationship to patient _________________________________ if relationship is other than parent, documentation of legal authorization(s) or Guardianship must be attached.