**Gwinnett Pediatrics and Adolescent Medicine**
595 Hurricane Shoals Rd. NW Ste.300
Lawrenceville GA 30046
PHONE: 770-995-0823 FAX: 770-995-7018

# Access Request and Authorization for Use and Disclosure of Protected Health Information

**Patient Identification** (If requesting for multiple children, use one form per child/ patient)

Name:_____ Date of Birth:_____

Street Address:_____ Tel # (cell):_____

City, State ZIP:_____ Tel # (home):_____

Email Address:_____

**I request my records to be delivered by:** ☐ Electronic Delivery ☐ Mail (paper) ☐ Picked Up (paper) ☐ Fax to Healthcare Provider

**I hereby authorize** (facility or person **releasing** the records) _____
PHONE:_____ FAX:_____ **to Disclose my Protected Health Information to:**

Facility/Individual Name:_____ Relationship:_____

Attention:_____ Fax #: _____

Street Address:_____ Tel #: _____

City, State ZIP:_____ Email Address:_____

**Information Be Released for TREATMENT DATES: From (date):** _____ **To (date):** _____

**TYPE OF INFORMATION TO BE RELEASED:**

☐ Office Notes & Immunizations only
☐ Physical Therapy Notes
☐ Itemized Billing Statement
☐ Other:_____
☐ Other:_____
☐ Radiology Reports Only
☐ Complete Health Record
☐ Other:_____
☐ Other:_____

**PURPOSE OF THE REQUEST for PHI DISCLOSURE:**

☐ Treatment/Consultation
☐ Personal Request
☐ Insurance
☐ Legal (specify):_____
☐ Other (specify):_____

**Drug and / or Alcohol Abuse, and / or Psychiatric, and / or HIV / AIDS Records Release:**
I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. ***Check one:*** **Yes** **No**

**Time Limit & Right to Revoke Authorization:**
Except to the extent that action has already been taken in reliance on this Authorization, you have the right to revoke this Authorization by submitting a notice in writing to the Department of Health Information Systems or other Department to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event_____ , or 90 days from the date of signature, unless otherwise specified.

**Re-release:**
I understand that the information released pursuant to this Authorization may be subject to release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**Cost of Records:**
The cost of copies of **medical records for your personal use is $6.50 (electronic)** ***per request*****, with payment due in advance and made payable to Gwinnett Pediatrics**. Requests for continuing care and records provided directly to another healthcare provider will be at no cost, unless transferring to another healthcare provider, and all other requests will be billed at applicable rates. Please **contact Gwinnett Pediatrics at 770-995-0823 for questions** regarding your record request.

**Signature of Patient or Personal Representative Who May Request Disclosure**
By signing below, you authorize your healthcare provider identified above to release your protected health information, and acknowledge and understand the terms of this **Request for Access to and Authorization for Use and Disclosure of Protected Health Information**.
Patient / Parent or Guardian signature: _____ Date: _____

Patient / Parent or Guardian printed name: _____

Relationship to Patient: _____