



GWINNETT PEDIATRICS AND ADOLESCENT MEDICINE
Release of Medical Information

Main Office

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Duluth, GA 30096

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Suite 370
Lawrenceville, GA 30045

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Suite 100
Dacula, GA 30019

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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. These charges only apply if Gwinnett Pediatrics is releasing the records. Fee is not required for records that are released directly to another physician.**

*** 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.