



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)	Chart Notes
Patient Summary of all visits	Consultation Notes
Immunizations Only	Other: _____
Radiology/ EKG/ Lab Reports	

****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:

<p>From To Gwinnett Pediatrics (Select Address Above)</p>	<p>Please release the requested records: From To Practice Name _____ Address: _____ _____ Phone: _____ Fax: _____</p>
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*** 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.