Authorization for Release of Medical Information

**595 Hurricane Shoals Rd. Suite 300  
Lawrenceville, GA 30046  
770-995-0823 Voice 770-995-7018 Fax  
www.GwinnettPeds.com**

Patients Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_  
  
Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Request\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Gwinnett Pediatrics and Adolescent   
 Medicine **to obtain information from:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name of Provider or Facility   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
City, State, Zip Code  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone Number Fax Number

OR

I authorize Gwinnett Pediatrics and Adolescent   
Medicine **to release information to:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name of Provider or Facility   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Address   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
City, State, Zip Code  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Phone Number Fax Number

**I understand that:**

* My right to healthcare treatment is not conditioned on this authorization.
* I may cancel this authorization at any time by submitting a written request to the address provided the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
* If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
* Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.

Signature of Patient or Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Relationship to Patient (If requester is not the patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PURPOSE FOR THIS REQUEST** (check one) Transfer of Care  Healthcare  Insurance Coverage Personal (Release Fee)   
**TYPE OF RECORDS REQUESTED** (check one)  
Immunization History  Summary of records (Includes: Immunizations, last well check, detailed summary of all visits, growth chart, allergies, and medication list) (No Cost)  
All Medical Records related to a specific illness or injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Specific illness /injury Date of treatment  
 Complete medical record (Printout of each visit (2-4 pages per visit), labs, consult letters, immunization, growth chart)  
 Specific Treatment (select one or more, as applicable)  
 Procedure Report History & Physical Physical Therapy X-Ray Reports Lab Results   
**AUTHORIZATION VALID FOR:** (Check one)  
This request only.  
One year from the date of this authorization. This authorization applies to the records of the treatment received on or prior to the date of this authorization.   
 This request and for medical records of any **future** treatment of the type described above until :\_\_\_\_\_\_\_\_\_\_\_\_( insert date)