



Gwinnett Pediatrics and Adolescent Medicine

595 Hurricane Shoal Road Rd. NW Ste.300

Lawrenceville GA 30046

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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: Digital (USB/CD) Mail (paper) Fax

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 _____ **To (date):** _____

(date): TYPE OF INFORMATION TO BE RELEASED:
 Office Notes & Immunizations only Radiology Reports Only
 Physical Therapy Notes Labs Only
 Itemized Billing Statement
 Other: _____ Other: _____
 Other: _____ Other: _____

Reason for request (REQUIRED ANSWER):
 Transferring to a new doctor
 Personal Request
 Specialist
 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 \$20 (electronic)per request, with payment due in advance.** Requests for continuing care and records provided directly to another healthcare provider will be at no cost. Unless transferring to another healthcare provider, 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 (Patients 18 yrs. and up must signed by patient)
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: _____