Gwinnett Medical Group
Adult Primary Care Associates

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Lawrenceville, GA 30046
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Fax: 678-225-0209

Gwinnett Health System

AUTHORIZATION FOR RELEASE / DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby request and authorize ❑ Gwinnett Health System to release records or other items as described below:
I hereby authorize ❑ _____ to release items as described below to Gwinnett Health System:

❑ Continued Treatment ❑ Insurance ❑ Attorney ❑ Personal ❑ Other: _____

Patient's Full Name (print): _____
Date of Birth: _____ Medical Record #: _____
Social Security #: _____ Phone # Home: _____ Work: _____
Current Address: _____

I further request and authorize:

❑ Center for Cancer Care
❑ Center for Weight Mgmt
❑ Diabetes/Nutrition Ed
❑ Duluth Outpatient Center
❑ Glancy Rehab Center
❑ Gwinnett Breast Center
❑ Gwinnett Extended Care
❑ Gwinnett Medical Center-Duluth
❑ Gwinnett Medical Center
❑ Gwinnett Medical Group
❑ Gwinnett Sports Rehab
❑ John's Creek Orthopedic
❑ Pain Clinic
❑ Wound Treatment Ctr
❑ **All Facilities**

❑ **Other:** _____
to release the medical/financial records or other items checked below to:
Name: _____
Organization: _____
Address: _____

❑ by Mail ❑ Picked up by Person Named Above ❑ by Fax to #: _____ (for treatment purposes only) ❑ Picked up by Patient/Personal Rep.

This Authorization applies to the information checked below for the date(s) of service on: _____

❑ Autopsy Report
❑ Cardiac Cath Report
❑ Discharge Summary Reports
❑ Electrocardiogram (ECG/EKG) Reports
❑ Emergency Department Record
❑ **Entire Medical Record**
❑ Face Sheet
❑ Fetal Monitor Strips
❑ **Financial Record**
❑ Laboratory Test Results
❑ Office Visit Records
❑ Operative Report
❑ Pathology Report
❑ Pathology Slides/Blocks
❑ Physical/Occupational Therapy Notes
❑ Radiology Films
❑ Radiology Reports
❑ Explanted Medical Device – specify: _____
❑ **Other – please specify:** _____

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that I may revoke this Authorization at any time by presenting my revocation in writing on the Gwinnett Health System Authorization Revocation form, except to the extent that Gwinnett Health System has taken action in reliance on this Authorization. I further understand that this Authorization is specific to the information checked above, for the date of services indicated, and for the purpose written above. I understand that this disclosure may include psychiatric, drug/alcohol, and/or HIV testing results, and/or AIDS related information. Gwinnett Health System shall not condition treatment on the receipt of this Authorization.

This authorization and/or request to release information from my protected health information (PHI) is fully understood and is made voluntarily on my part and includes faxing of PHI. I understand that a photostatic or faxed copy of this authorization is as valid as the original.

I further understand that this Authorization is valid for a period of 1 (one) year from today's date and will expire at that time unless an earlier date is written here: _____

I understand there may be a copy charge and upon request, I may obtain the fee schedule.

_____ _____
Patients or Legal Representative's Signature Today's Date

If signing as legal representative for the patient, signee must complete GHS form #19000.