Gwinnett Medical Group, Inc

Gwinnett Physician's Group OB/Gyn
1942 Atkinson Road, Suite 100
Lawrenceville, GA 30043
Ph- 678-775-0600 **Fx-**678-377-5284

AUTHORIZATION FOR RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Full Name: (print) _____

Date of Birth: _____ Social Security #: (Last 4 digits only)_____

Current Address: _____

Phone#: Home _____ Work _____

I hereby request and authorize Gwinnett Medical Group, Inc./Gwinnett Physicians Group OB/Gyn:

1. ☐ **To obtain copies of medical records from:**

Name/Organization: _____
Address: _____
Phone#: _____ **Fax#**_____

2. ☐ **To release my medical/financial records to:**

Name: _____
Address: _____
Phone#: _____ **Fax#:** _____

3. ☐ **To communicate verbally with:** _____

For the purposes of: ☐Continued Treatment ☐Insurance ☐Attorney ☐Personal/Other_____

My released records can be:

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

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

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

Please specifically describe other required information: _____

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 to Gwinnett Physicians Group OB-Gyn, except to the extent that Gwinnett Physicians Group OB/Gyn 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 Physicians Group 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 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.

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