500 Medical Center Blvd, Suite 250. Lawrenceville, Georgia 30046
1120 Peachtree Industrial Blvd, Suite 209. Suwanee, Georgia 30024
Phone: 770-979-4700 Fax: 770-979-1060
www.womensgroupofgwinnett.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Social Security #: _____ Primary Phone#: _____

RELEASE RECORDS FROM:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

RELEASE RECORDS TO:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

INFORMATION TO BE RELEASED:

____ My complete office notes/lab results

____ History and Physical Exam

____ Lab Report

____ X-Ray Report

____ Other (specify) _____

From & To Dates: _____

I understand that this health information may include HIV related information and/or information relating to diagnosis or treatment of psychiatric abilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of this information. This material shall not be transmitted to anyone without signature consent provided below.

Purpose of Disclosure_____

I understand that this authorization will expire two years from my last date of visit. A photocopy of this form will be considered as valid as the original.
I understand that I may revoke this authorization at any time by notifying the Privacy Officer where my records are retained.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION.

_____

Signature of Patient Date

_____

Parent/Legal Guardian Date

Please allow 7-10 business days to process your request.