Updated April 2016

GWINNETT CLINIC

AUTHORIZATION FOR GWINNETT CLINIC TO *DISCLOSE* YOUR HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: ________________________________ **Date of Birth:** ________________________________

Phone Number: (________) ________________________

Address: ________________________________ **City**: ______________ **State**: ______ **Zip**: __________

RECEIVING PROVIDER/PARTY/PERSON

I hereby request and authorize Gwinnett Clinic to send my protected health information to:

Name of Provider/Party/Person: ____

Phone Number: (________) ________________________ **Fax Number:** (________) ________________________

Address: ________________________________ **City**: ______________ **State**: ______ **Zip**: __________

SENDING GWINNETT CLINIC OFFICE

I hereby request and authorize a staff member at the below office to send my protected health information to the named Provider/Party/Person.

(Stamp here)

PROTECTED HEALTH INFORMATION TO BE SHARED AND PURPOSE

□ Last office note *or* □ Specific records ________________________________ within the following dates: __________

For the following purpose: □ Patient request □ Care coordination □ Transfer care □ Other: ________________________

I understand that the information used/disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. A completed revocation must be presented to the Medical Director by certified mail. I further understand that this Authorization is specific to the information checked above, for the date(s) of services indicated, and for the purpose written above ***. I understand that this Authorization may include release of all medical records including those pertaining to HIV, mental health, substance abuse, sexually transmitted diseases, genetic testing, and other statutory protected diseases. I understand that this Authorization is valid for a period of 90 days from today's date and will expire at that time unless another date is written.*** *Finally, Gwinnett Clinic shall not condition treatment on the receipt of this Authorization, except in instances where the sole purpose of creating the health information is for disclosure to a third party (e.g., immigration physicals).*

________________________________ ________________________________

Signature of Patient or Personal Representative Date of Signature

________________________________ ________________________________

Printed Name of Patient or Personal Representative Description of Personal Representative's Authority

____

Signature of Witness (if Representative signing)

This form should be used when you want Gwinnett Clinic to send your medical records to another provider/person/entity. Under most circumstances, the law permits up to 30 days for processing requests. ***You will be charged standard fees (set by the State of Georgia) for each records requests.***