

GWINNETT CLINIC

AUTHORIZATION FOR GWINNETT CLINIC TO REQUEST YOUR HEALTH INFORMATION

PATIENT INFORMATION			
Patient Nama	Date of Birt	Date of Birth:	
Patient Name:	Phone Num		
Address:	City:	State: Zip:	
SENDING PROVIDER/PARTY/PERSO	N		
I hereby request and authorize named Pro-	ider/Party/Person to send my p	protected health information to Gwinnett (
Name of Provider/Party/Person:			
Phone Number: ()	Fa	ax Number: ()	
RECEIVING GWINNETT CLINIC OF			
I hereby request and authorize staff at the	elow office to receive my protec	ected health information:	
	(Stamp here)		
PROTECTED HEALTH INFORMATION			
□ All outpatient and inpatient records (incl		scedure reports) from the past one year	
	Or		
□ Specific records	,	within the following dates:	
For the following purpose: Care coordi			
I understand that Gwinnett Clinic and the name	d sending provider will not conditi	tion my ahility to receive care on providing or	
refusing to provide this authorization. Once this			
further discloses it may no longer be protected			
require fees or additional steps to process my r			
release of all medical records including those	9		
genetic testing, and other statutory protected of			
signed. I understand that I may revoke this aut. previously released information.	grization and consent at any time,	, nowever, my revocation will not apply to any	
F			
Signature of Patient or Personal Representa	tive Date of Sign	natura	
or i anom of i cisonal representa	Date of Sign	natare	
Printed Name of Patient or Personal Repre	entative Description	of Personal Representative's Authority	
Timed Ivanic of Latient of Leisonal Reple	manve Description	of reisonal representative's Authority	
Signature of Witness (if Representative sig			

This form should be used when you want a health care provider to send your medical records to Gwinnett Clinic.