

GASTROENTEROLOGY SPECIALISTS OF GWINNETT

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

721 Wellness Way, Suite 100, Lawrenceville, GA 30046 | Phone: 770-995-7989 | Fax: 770-995-3113

1. PATIENT INFORMATION

Patient full legal name: _____ Date of birth: _____
Address: _____ Phone: _____

City / State / ZIP: _____ Email (optional): _____
Former name(s), if applicable: _____ Medical record number (if known): _____

2. RELEASE RECORDS (Select one)

- ☐ Gastroenterology Specialists of Gwinnett may RELEASE records TO the recipient listed below.
☐ Gastroenterology Specialists of Gwinnett may REQUEST/RECEIVE records FROM the provider or facility listed below.
☐ Exchange records in both directions, as specified below.

3. PROVIDER / RECIPIENT INFORMATION

Provider / facility / person name: _____ Attention / department: _____
Address: _____ Phone: _____

City / State / ZIP: _____ Fax: _____

4. RECORDS AUTHORIZED FOR RELEASE

Date range requested: From _____ To _____
☐ Entire medical record ☐ Office/visit notes ☐ Consultation reports ☐ Lab results
☐ Imaging / radiology reports ☐ Endoscopy / colonoscopy reports ☐ Pathology reports
☐ Medication list ☐ Procedure / operative reports ☐ Billing records ☐ Other: _____
Specific information or limitations (if any): _____

5. PURPOSE OF DISCLOSURE

☐ Continuing care / treatment ☐ At the request of the patient ☐ Insurance / payment ☐ Legal ☐ Other: _____

6. DELIVERY METHOD

☐ Secure fax ☐ Mail ☐ Patient pickup ☐ Secure electronic transmission ☐ Other: _____
Send records to (if different from recipient above): _____

7. AUTHORIZATION, RIGHTS, AND ACKNOWLEDGMENT

- I authorize Gastroenterology Specialists of Gwinnett and its workforce, as applicable, to use or disclose the medical information described in this form to the person or organization identified above, for the purpose and by the method selected.
- I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it. I may send a written revocation to Gastroenterology Specialists of Gwinnett at the address listed above.
- I understand that treatment, payment, enrollment, or eligibility for benefits generally will not be conditioned on whether I sign this authorization, except where applicable law permits otherwise.
- I understand that information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy law, except as otherwise provided by law.

- This authorization expires on (date or event): _____. If no expiration is entered, the practice should confirm and apply the expiration permitted by applicable law and its policy before processing.
- I acknowledge that I have had the opportunity to review this form and receive a copy upon request.

8. SIGNATURE

Patient / personal representative signature: _____

Date signed: _____

Printed name: _____

Relationship / authority (if representative): _____

If signed by a personal representative, describe authority and attach documentation if required: _____

9. PRACTICE USE ONLY

Identity / authority verified by: _____

Date received: _____

Processed by: _____

Date completed: _____

Method / destination verified: _____

Notes: _____

Physicians: William Tanner, MD • Brad Lord, MD • Jae Nam, MD • Olaitan Adeniji, MD • Shahzad Ahmed, MD