GWINNETT SURGICAL ASSOCIATES
631 Professional Dr, Suite 300 Lawrenceville, GA 30046
Phone: 770.962.9977
FAX: 770.339.9804

MEDICAL RECORDS REQUEST

By signing this authorization, I authorize _____

to disclose certain protected health information (PHI) about me to or for Gwinnett Surgical Associates. This authorization permits _____ to use or disclose the following individually identifiable health information to Gwinnett Surgical Associates _____

_____

_____

This authorization expires on _____.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the above listed facility has acted in reliance upon this authorization. My written revocation must be submitted to the above listed facility.

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Patient's Name — Patient Date of Birth

_____ _____
Printed Name of Patient or Legal Guardian — Date