Gwinnett Surgical Associates
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Lawrenceville, Georgia 30046
Phone. 770.962.9977
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Medical Records Request/Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician/surgeon/person/facility/entity listed below.

Patient Name:_____

Date of Birth:_____

Release Medical Records to: _____

Obtain Medical Records From: _____

The information you may release subject to this signed release form is as follows:

_____
_____
_____
_____

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