AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Georgia Dermatology Partners
2383 Pate Street
Snellville, GA 30078
Phone: (770) 972-4845 • Fax: (770) 972-0358

Please complete form thoroughly. Your medical records cannot be released until this form is completed and signed by the patient, or legal guardian. **Please note:** ***All patient records are available at no charge on your patient portal.*** *If you need assistance accessing your portal, please let us know.*

PLEASE PRINT!!

Patient Name: ____ Date of Birth: _____________________
Last First MI

Address: ____
Street City State Zip

Phone Number: ____________________________ Alternate Phone: ___________________________

Information Requested to Be Released:

☐ I would like copy of my record to be sent to another medical provider. (There is no fee associated with requests for continuity of care).

Name: ____
Address: ____
____
Phone #: ________________________ Fax #: ______________________

☐ I would like a copy of my complete medical record. I understand that I am financially responsible for the following fees associated with my request:

☐ $25.00 fee for standard processing (7 – 10 business days)
☐ $15.00 additional fee for rush processing (2 business days)

☐ I request the release of a copy of my report. Select one: ☐ Pathology Report ☐ Laboratory Report ☐ Consultation Report

Please Indicate Your Preferred Method of Delivery of Your Health Information:

☐ I will return to Gwinnett Dermatology to pick up my records when ready. Please call: (_____)________________________
☐ I would like for Gwinnett Dermatology to mail a copy via US mail to the following address:

Name: ____
Address: ____
____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Please check if you do not authorize the release of the following:
____ Mental Health Records ____ Communicable Diseases (Including HIV and AIDS) ____ Alcohol/Drug Abuse Treatment

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will last for one year after the date you sign it unless you enter a different expiration here: _______________.

____ ______________________________________
Patient/Legal Guardian Signature Date