GWINNETT INTERNAL MEDICINE ASSOCIATES, LLC

MEDICAL RECORDS REQUEST FORM/RELEASE AUTHORIZATION

Patient's Name: _____ Date of Birth: _____

Record #: _____

Phone/Cell #: _____

I hereby authorize and request that my complete medical history and records or portion specified below currently in your possession concerning my illness and/or healthcare treatment be released.

Records requested: _____ complete file _____ most recent labwork/test results

Physician to **release** records: _____

I have been informed of, and agree to pay the fee of $15.00 to copy/print records I have requested. Payment is to be made at the time records are received.

I am aware that some of the healthcare information or other information contained in the requested medical records may be confidential or privileged and I hereby specifically waive any privilege or confidentiality existing under federal or state law regarding such information, but not limited to, protection afforded to:

- AIDS Confidential Information
- Medical Information Concerning Alcohol and Drug Abuse Psychologist
- Medical Information
- Medical Information Regarding Mental Illness/Mental Retardation
- Communications Made to Psychiatrist/Licensed Applied Psychologist

This authorization and consent is subject to revocation at any time except to the extent that action has already been taken in reliance to it. If not previously revoked, this authorization will terminate 90 days from the date appearing below.

_____ _____

Signature of Patient or Legal Guardian Date