Gwinnett Psychiatry, P.C. 170 Camden Hill Road, Suite C Lawrenceville, GA 30045 Phone: (678) 226-2295 / Fax: (678) 226-2296

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:	DOB:	SSN:
I authorize and request that Nasira Rubina, M.D.,	its employees and a	igents:
Release to:		
Address:		
City, State & Zip:		
The following information from the medical reco	rd pertaining to the	patient named above:
Entire Psychiatric Records Laboratory Test		st)
I authorize this information for the following reas	on and/or purpose:	
Continuity and/or coordination of Other (Specify)		
I understand that the medical records released concerning drug related conditions, alcoholism, bloodborne infectious disease, which are subjeunderstand this information will not be forward consent. I also understand that I may revoke this action has taken in reliance on it. Time & Fee: The fee for hand written medical record(s) is \$20 mail this form along with a check, payable to Gw credit card information below. Once the request is record(s) to release. Note. The computer-general	psychological condect to federal and/ored to anyone else le consent in writing, per request. Use a sinnett Psychiatry, se received, it takes 3	or state restrictions on disclosure. It is the recipient without any written at any time except to the extent that eparate form for each request. Please P.C. Or charge it by filling out the -5 business days for medical
I further understand that except as already acted us for release of information at any time, and authorization will expire 90 days after the Expiration/Extension Date:	ipon, I may, by writ that unless another date on the re	ten request, revoke this authorization date is specified in writing, this lease, unless otherwise indicated
SIGNATURE: Patient, Parent, or Legal Guardia		ATE:
Master / Visa #	E	xpiration:
Amount: \$	Signature:	