TOBACCO FREE CAMPUS

Whose Patient Information is Being Released?

PATIENT NAME	DATE OF BIRTH	LAST 4 DIGITS OF SS#	
ADDRESS	CITY	STATE	ZIP

Where Should We Send Records?

NGHS LOCATION	CONTACT NAME		
NAME/ORGANIZATION			
ADDRESS	CITY	STATE	ZIP
PHONE	FAX (healthcare providers only)		

What Records or Reports Should be Released?

DATES OF SERVICE _____

❑ Discharge Summary ❑ History & Physical ❑ Consultations ❑ Clinic Notes ❑ Abstract/Summary
❑ Radiology ❑ Surgical Reports ❑ Laboratory Results ❑ Pathology Reports ❑ Emergency Notes
❑ All Records ❑ Other: _____

❑ Check here if release should include any psychiatric, substance abuse, genetic and HIV/AIDS information (otherwise, they will be excluded).

LOCATION OF SERVICES TO RELEASE *(please check all that apply)*

❑ NGMC Gainesville ❑ NGMC Braselton ❑ NGMC Barrow ❑ Hospice
❑ The Heart Center ❑ New Horizons ❑ NGPG (specify locations): ❑ Other: _____
_____

What Format and Delivery Method Would You Prefer?

Format: ❑ Paper ❑ CD/DVD ❑ Thumb Drive (USB) ❑ Electronic Upload ❑ Other: _____

Delivery Method: ❑ Mail ❑ Pick-up ❑ MyChart *(patient portal)* ❑ Fax *(providers only)* ❑ Other: _____

What is the Purpose of the Release?

❑ Insurance ❑ Personal ❑ Treatment ❑ Legal
❑ Other: _____

The information disclosed may be subject to re-disclosure by the recipient and will no longer be protected by the Privacy Protections, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, and may no longer be protected by the Health insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

- I hereby authorize Northeast Georgia Health System and/or their business partners to disclose/release medical records and/or other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable for legal, insurance, and/or personal use.
- I hereby release Northeast Georgia Health System and/or their business partners from any liability which may result from this disclosure of confidential medical information, or which may arise as a result of the use of the information contained in the information released. I understand that I may revoke this authorization by providing written notice of my intention. Unless withdrawn, this consent will expire in thirty (30) days from the date signed.

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **DATE**

_____ _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT **SIGNATURE OF WITNESS (IF APPLICABLE)**

Office Use Only: Paid by: ❑ Cash ❑ Card ❑ Check ❑ Paid on site ❑ Send Invoice Log ID# _____ **Completed by:** _____ **❑ Scanned**

Northeast Georgia Health System is not a provider of patient care services; rather, it is a parent organization of a family of affiliate care providers providing health information management services through its Health Information Department.

Northeast Georgia Medical Center® Northeast Georgia PHYSICIANS GROUP The Heart Center of Northeast Georgia Medical Center

PATIENT IDENTIFICATION:

CONSENT FOR RELEASE OF INFORMATION

C–45

Northeast Georgia Medical Center | Northeast Georgia PHYSICIANS GROUP | The Heart Center of Northeast Georgia Medical Center

TOBACCO FREE CAMPUS

CONSENT FOR RELEASE OF INFORMATION

Fee Schedule Acknowledgement Form

In order to process your request for medical records, we need you to fill out this form completely (front and back side).

Return the completed form with a copy of your photo identification or driver's license to:

MAIL TO	DELIVER TO	FAX
Health Information Management PO Box 908131 Gainesville, GA 30501	**Health Information Management** 3137 Frontage Road Oakwood, GA 30504	770-219-6903

Medical Records Copy Fees* for Patients	
Paper Records:	
Reproduction Flat Fee	$0.90
plus per page fee	$0.05
Jump Drive (USB Flash Drive)	$6.50
Certification Fee	$9.70
Maximum charge for record retrieval is	***$400.00***

The fees associated with obtaining medical records are governed by the Georgia Department of Community Health and are NOT applicable when records are needed for continuity of care, or to make or complete an application for a disability benefits program or vocation rehabilitation program.

Fees associated with obtaining records for Workers' Compensation may differ than those listed above.

PAYMENT ❑ Debit / Credit Card ❑ Personal Check ❑ Cash

PATIENT NAME

SIGNATURE OF PATIENT OR REPRESENTATIVE

DATE SIGNED | RELATIONSHIP TO PATIENT

PATIENT IDENTIFICATION:

FORM # C-45 (9/27/17)