

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? OR Who Should We Request Records From?

NGHS LOCATION	CONTACT NAME			If we are requesting records from you, please return to:	
NAME/ORGANIZATION				Fax # _____	
ADDRESS				CITY	STATE ZIP
PHONE				FAX (healthcare providers only)	
OUTSIDE STUDIES CAN BE MAILED TO:					

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 Delivery
 Email: _____

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 Unless withdrawn, this consent will expire in thirty (30) days from the date signed.

- This information may include Medical/Surgical, Psychiatric, Substance Abuse, Genetic and HIV/AIDS information.
 I authorize that this information may be faxed to the requesting Health Care Provider.

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.



PATIENT IDENTIFICATION:

CONSENT FOR RELEASE OF INFORMATION



C-45 A

FORM # C-45 A (11/5/19)

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

Health Information Management
743 Spring Street
Gainesville, GA 30501

DELIVER TO

Health Information Management
3137 Frontage Road
Gainesville, GA 30504

FAX

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) or edelivery	\$6.50
Certification Fee	\$9.70
Maximum charge for record retrieval is	\$400.00

My signature below signifies that I have received _____ pages of medical records from NGHS HIM on _____ (date).

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: