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? OR ❏ Who Should We Request Records From?

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

If we are requesting records from you, please return to:

Fax # ______________________

Attn. ______________________

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: Radiation Therapy-Dicom files (CT Structures, Plan, Dose, DVH, PDF of Tx Plan)
❏ 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 Method: ❏ Mail ❏ Pick-up ❏ Fax *(providers only)* ❏ Email: ______________________

Receive your records via Electronic Patient Portal: ❏ MyChart – *You must be signed up for MyChart to select this method.*
If you have not signed up for the MyChart patient portal please visit: https://mychart.nghs.com/mychart/accesscheck.asp
or call MyChart Support at 770-219-1963 to sign up.

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)**

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

FORM # C-45 RT A (12/18/2020)

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

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.

PATIENT IDENTIFICATION: