

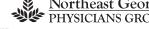
Whose Patient Information is I	Being Released?					
PATIENT NAME		DATE OF BIRTH		LAST 4 DIGITS OF	SS#	
ADDRESS		CITY		STATE	ZIP	
Are we requesting records 🗆 o	or sending records	」 ?			-	
SEND RECORDS TO		REQUEST RECORDS FF				
NGHS LOCATION	CONTACT NAME			ting records from yo		
NAME/ORGANIZATION						
ADDRESS	CITY	STATE ZIP		IES CAN BE MAILED		
PHONE	FAX (healthcare providers only)	<u>'</u>				
LOCATION OF SERVICES/RECORDS TO NGMC Gainesville □ NGMC Brase □ Georgia Heart Institute □ New Horizon □ Neurological Center of North GA (Billing of the North GA)	Iton INGMC Barrow S INGPG (specify loc	NGMC Habershar rations):		•	Hospice	
What Records or Reports Sho	uld be Released?					
DATES OF SERVICE						
□ Radiology □ Laboratory Re □ Cardiology □ Radiation The □ All Medical Records □ Designated R	sical Consultations esults Pathology Re erapy-Dicom files (CT Struct ecord Set (All Medical Reco	□ Surgical, ports □ Emerger tures, Plan, Dose DVI	/Procedure Rep ncy Room Note H, PDF or Tx P	es □ Clini Ian)	ic Notes ng Records	
☐ Other:						
What Format and Delivery Met						
Format: □ Paper □ CD/DV *This option is only available if you have a l https://mychart.nghs.com/mychart/accesscl				yChart Patient Po For log in	ortal*	
Delivery Method: ☐ Mail ☐ Pick-up	Fax (providers only)	☐ Email:				
What is the Purpose of the Rel	ease?					
-	rsonal	☐ Treat	tment	☐ Lega	al 	
The information disclosed may be subject to for Alcohol and Drug Abuse as defined in 42 Act Privacy Rule [45 CFR Part 164], and the Information obtained in the course of mor personal use. I hereby release Northeast Georgia Hereby Release Northeast	CFR Part 2, and may no lor e Privacy Act of 1974 [5 US Health System and/or thei ny diagnosis and/or treatme alth System and/or their bu which may arise as a result orization by providing writte	nger be protected by the C 552a]. If business partners to nt. I agree to pay copusiness partners from a tof the use of the information notice of my intention.	ne Health insurated disclose/releated to disclose/releated to the charges if apparent in the contained to th	ance Portability are see medical recorplicable for legal, ch may result from ned in the informations, this constructions.	dd Accountability ds and/or other insurance, and/ n this disclosure ation released. I	
☐ This information may include Medical/Sui			HIV/AIDS info	ormation.		
☐ I authorize that this information may be fa	axed to the requesting Heal	th Care Provider.				
SIGNATURE OF PATIENT OR LEGAL REPRESENTAT	ΓΙVE	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

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 743 Spring Street Gainesville, GA 30501 **Health Information Management** 3137 Frontage Road Gainesville, GA 30504

770-219-6903

Medical Records Copy Fees* for Pa	tients
Paper Records:	
Reproduction Flat Fee	\$0.90
plus per page fee	\$0.05
Jump Drive (USB Flash Drive) or edelivery	\$6.50
Certification Fee	\$7.50
Maximum charge for record retrieval is	\$400.00

My signature below signifies that	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	N:	