TOBACCO FREE CAMPUS

Whose Patient Information is Being Released?

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

Are we requesting records ❑ or sending records ❑ ?

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

LOCATION OF SERVICES/RECORDS TO BE RELEASED *(please check all that apply):*

❑ NGMC Gainesville ❑ NGMC Braselton ❑ NGMC Barrow ❑ NGMC Habersham ❑ NGMC Lumpkin ❑ Hospice
❑ Georgia Heart Institute ❑ New Horizons ❑ NGPG (specify locations): _____
❑ Neurological Center of North GA *(Billing Records Only)* ❑ Other: _____

What Records or Reports Should be Released?

DATES OF SERVICE _____

❑ Record Abstract/Summary (History/Physical, Consults, Surgical, Radiology, Discharge Summary)
❑ Discharge Summary ❑ History & Physical ❑ Consultations ❑ Surgical/Procedure Reports
❑ Radiology ❑ Laboratory Results ❑ Pathology Reports ❑ Emergency Room Notes ❑ Clinic Notes
❑ Cardiology ❑ Radiation Therapy–Dicom files (CT Structures, Plan, Dose DVH, PDF or Tx Plan)
❑ All Medical Records ❑ Designated Record Set (All Medical Records + Imaging/Billing) ❑ Billing Records
❑ Other: _____

What Format and Delivery Method Would You Prefer?

Format: ❑ Paper ❑ CD/DVD ❑ Thumb Drive (USB) ❑ Digital/Electronic ❑ MyChart Patient Portal*

**This option is only available if you have a NGHS MyChart account (Call MyChart Support at 770-219-1963 or log in https://mychart.nghs.com/mychart/accesscheck.asp to sign up)*

Delivery Method: ❑ Mail ❑ Pick-up ❑ Fax *(providers only)* ❑ Email: _____

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.

Northeast Georgia Medical Center
Northeast Georgia PHYSICIANS GROUP
GEORGIA HEART INSTITUTE

PATIENT IDENTIFICATION:

C-45 A

CONSENT FOR RELEASE OF INFORMATION

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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 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	$7.50
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: