

Whose Patient Information is Be	ing Released?						
PATIENT NAME		DATE OF BIRTH	LAST 4 DIGITS OF	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	l be Released?						
DATES OF SERVICE							
☐ Discharge Summary ☐ History & Physica	,		☐ Abstract/Sum	mary			
□ Radiology □ Surgical Reports	☐ Laboratory Re	esults	☐ Emergency N	=			
☐ All Records ☐ Other:	-						
☐ Check here if release should include any psyc	niatric, substance abuse, q	enetic and HIV/AIDS information (other	wise, they will be excl	uded).			
LOCATION OF SERVICES TO RELEASE (please check ali		(11111111111111111111111111111111111111					
□ NGMC Gainesville □ NGMC Braselton		v	☐ Hospice				
☐ The Heart Center ☐ New Horizons	□ NGPG (specif	PG (specify locations):		Ū Other:			
		,					
What Format and Delivery Metho	d Would You Pre	fer?					
Format:	/D 🗖 Thumb Drive	(USB) Electronic Upload	☐ Other:				
Delivery Method: ☐ Mail ☐ Pick-u	p	ent portal)	☐ Other:				
What is the Purpose of the Relea	se?						
☐ Insurance ☐ Person	nal	☐ Treatment	☐ Lega	al			
☐ 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 of confidential medical information, or whi understand that I may revoke this authoriz thirty (30) days from the date signed. 	ch may arise as a result	t of the use of the information cont	ained in the informa	ation released. I			
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE						
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSH	IP TO PATIENT	SIGNATURE OF WITNESS (IF APPLICA	BLE)				
Office Use Only: Paid by: Cash Card Check Paid on site Send Invoice Log ID#Completed by: Completed by: C							
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.							

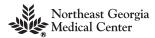






PATIENT IDENTIFICATION:











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

Health Information Management PO Box 908131

Gainesville, GA 30501

DELIVER TO

Health Information Management

3137 Frontage Road Oakwood, 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)	\$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 C	R REPRESENTATIVE				
DATE SIGNED		RELATIONSHIP TO PAT	TIENT		_
				PATIENT IDENTIFICATION:	_