Central Georgia Health System

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

The Medical Center of Central Georgia
Health Information Management MSC #148
777 Hemlock Street
Macon, GA 31201-1202

I authorize and request the disclosure of protected information FROM:

☐ Medical Center of Central Georgia
☐ WT Anderson Health Center
☐ Childrens Hospital
☐ Med Center North
☐ Med Center East
☐ Med Center Northwest
☐ Other (specify):________________________
☐ Central Georgia Rehabilitation Hospital
☐ Central Georgia Home Health
☐ Central Georgia Wound Care
☐ Hospice of Central Georgia
☐ Sibley Heart Center
☐ Clinic/Physician Practice (specify):
____

to release health information about the following patient: MR#____________________
(Office Use)

Print Patient Name: ____________________ Date of Birth ____________________

Street Address ____________________ Telephone Number ____________________

City, State and Zip Code ____________________

I expressly request that the information in the designated record set be disclosed for date(s) of treatment: _________________________ to include the following:

☐ Abstract – History & Physical, Consultations, Discharge Summary, Operative Report, Lab Reports, Radiology Reports, Other Diagnostic Reports, Emergency Center Physician Dictation
☐ Continuity Care Documents – Diagnostic Test Results, Problem List, Medication Lists, Medication Allergies, Discharge Summary, Procedures

☐ History & Physical
☐ Discharge Summary
☐ Consultations
☐ Operative Reports
☐ Pathology Reports
☐ Outpatient Rehab Records
☐ Lab Reports
☐ Radiology Reports
☐ EKG
☐ Emergency Center
☐ Progress Notes
☐ Health Center / Clinic
☐ Physicians' Orders
☐ Cardiovascular Reports
☐ Urgent Care Records
☐ Hospice Records
☐ Discharge Instructions
☐ Other (specify):
____

This protected health information is disclosed for the following purpose(s):

☐ Insurance ☐ Continued Treatment ☐ Legal
☐ Patient's / Representative's Request ☐ Other (specify):______________

You are authorized to release the above records TO the following:

Name ____________________ Title ____________________

Street Address ____________________

City, State and Zip Code ____________________

By Delivery Method: ☐ US Postal Service ● Electronic Delivery
☐ Pick – up ☐ Patient Portal ☐ USB ☐ Healthport Portal

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I understand the following:

a) I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization and submitted to The Medical Center of Central Georgia, HIM Department, 777 Hemlock, Hosp. Box 148, Macon, and GA 31201. The revocation will not affect any actions taken before the receipt of the written revocation.

b) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

CGHS healthcare entities and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychological or psychiatric conditions, and/or alcohol and drug abuse. I authorize the release or disclosure of this type of information.

______________________________________ ____________

Signature of Patient or Legal Authorized Representative **Date**

I understand that this authorization will expire in 90 days from the date of execution of this authorization unless I otherwise specify. I desire this authorization to be in effect until

______________________________________.

Expiration date and/or event

______________________________________ ____________

Signature of Patient or Legal Authorized Representative **Date**

____

Print Name

______________________ ______________________________

Relationship if other then patient **Street Address**

______________________ ______________________________

Telephone Number **City, State and Zip Code**

Office Use

☐ Legal authorized representative proof obtained and attached to this authorization

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The Medical Center of Central Georgia
777 Hemlock St. MSC 148
Macon, GA 31201

The release of patient information is governed under Federal and Georgia state statutes. Requests for information can be granted only with a valid authorization. All sections of the authorization must be completed for records to be released.

In order to verify your identification and validate your authorization, we require that you include a legible copy of a valid photo I.D. (e.g., driver's license, military I.D. or state I.D.)

At your request, we can send a copy of your record (s) to your physician without cost. You must provide the full name, address, telephone number, and fax number (if applicable) of the physician on the authorization.

For personal copies of your record (s), please see the information below regarding fees that will be charged based on Georgia Code Annotated 33-33-3. If you believe the record (s) you are requesting may exceed a certain dollar amount and would like us to notify you in advance, please indicate in the area below marked “Fee Approval”.

$.97 per page for pages 1-20
$.83 per page for pages 21-100
$.66 per page for pages 100+

FEE APPROVAL:
Please notify me if the cost of my records exceeds $ ______________.

By my signature below, I acknowledge that I am aware of the fee for copies of medical records. I agree to pay this fee when I received an invoice from HealthPort.

Please Print:
Name: ____

Address: ____
Street **City** **State** **Zip**

Phone: ____
Area Code **Phone Number**

______________________________ ________________________
Signature **Date**