Hughston Medical Records

Phone: 706-494-3374 or 1-800-331-2910

HUGHSTON

Authorization to Disclose Protected Health Information

Patient Information

Patient Full Name: _____ Other Names: _____

Patient Address: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____

Phone : _____ Email address: _____

Purpose of the Request

- ☐ Personal/Self
- ☐ Treatment: Physician/Provider
- ☐ Insurance
- ☐ Other:_____

Release records to: ☐ Above Address or Complete below:

Name: _____

Address: _____

City: _____State:_____ Zip:_____

Phone: _____

Attention: _____

Information to be Released

Type of Records requesting

- ☐ Office visit notes
- ☐ Operative Notes
- ☐ Physical/Occupation Therapy notes
- ☐ X-ray/MRI reports
- ☐ Radiology Disk: X-ray/MRI Images (+ $20.00)

Date Range of Records requesting:

- ☐ Specific date of service:_____
- ☐ From date: _____to _____
- ☐ Other: _____

I request that this authorization expire on the following date*: _____.

This is a one-time authorization and will automatically expire on the day the request is processed.

Delivery Method and Fees

How would you like your records?

- ☐ Digital Copy onto CD ($6.50)
- ☐ Paper (Cost per page)

Pursuant to HIPAA 45 CFR, 164-524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. At no time will the cost-based fees exceed State Law.

How would you like to receive your records?

- ☐ Send directly to Physician Office at above address
- ☐ Mail to me at above address (Postage Cost added)
- ☐ Pick up in the office (Limited Offices Available)
- ☐ Certified (Certified Mail Cost added)

Acknowledgement

I acknowledge and herby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, or AIDS information. _____ (Please initial)

I acknowledge and hereby consent to such, that I (the patient) understands the above cost associated with the medical records release of information. _____ (Please initial)

To ensure no delay in the completion on your medical records request, please confirm that you have filled out this form in its entirety.

Signature: _____ Date:_____

*Name of Patient representative:_____ Relationship:_____

If patient is a minor, then the parent or guardian must sign form.

*If patient is unable to sign, then a copy of the legal documentation (medical power of attorney, etc.) must be supplied.

FAX Completed Form to 706-494-3042