



Release of Information serviced by:
Healthport
PO Box 922788
Atlanta GA 30010-2788
Phone: 877-403-8825
Fax: 855-764-2382

Section A: This section must be completed for all authorizations to release medical records.

Patient Name:	Birth Date:	Social Security Number (optional):
Provider's Name: Redmond Regional Medical Center	Recipient: Name:	
Provider's Address: 501 Redmond Rd, Rome GA 30165	Address:	
	Phone #:	Fax#:

This authorization will expire on the following: (Fill in the date or the event, but not both):

Date: _____ Event: _____

Purpose of disclosure: Continuity of Care Personal health record Work/School Disability Military
 Insurance Other(specify): _____

Information to be disclosed from Redmond Regional Medical Center Other: _____

Description	Date(s)	Description	Date(s)	Description	Date(s)
<input type="checkbox"/> Discharge summary		<input type="checkbox"/> Operative report		<input type="checkbox"/> Emergency Dept	
<input type="checkbox"/> Abstract		<input type="checkbox"/> All records		<input type="checkbox"/> Discharge instructions	
<input type="checkbox"/> Medication records		<input type="checkbox"/> Rehab		<input type="checkbox"/> Wound Care	
<input type="checkbox"/> Pathology		<input type="checkbox"/> UB04		<input type="checkbox"/> Itemized Bill	
<input type="checkbox"/> Verify service dates/ level of care		<input type="checkbox"/> Test results (specify):		<input type="checkbox"/> Other (specify):	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information _____(initial). If not applicable, check here

I understand that:

1. This is strictly voluntary and I may refuse to sign this authorization.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any impact on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request for PHI for the purpose of marketing?

If yes, the provider or health plan must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?
No Yes. If yes, describe: _____

Section C: Signature:

Signature of Patient or Patient's Legal Representative:	Date:
Printed Name of Patient Representative:	Relationship to Patient:



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HCA contracts with Healthport to process requests for copies of medical records. The release of patient medical information is governed under federal and state statutes.

The following must be presented:

- A completed authorization (all sections of the authorization must be completed for records to be released)

What we will provide at no cost to you:

- Records sent to your physician/health care provider for continuity of patient care. Pertinent information (an abstract) for continuing care includes discharge summary, history and physical, operative reports and diagnostic test results.

Other requests:

- Requests directly to patients and recipients other than health care providers will be provided at a cost of:
 - 0.25 per page
 - Applicable tax
 - Postage

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 receive an invoice from Healthport.

Please notify me if the cost of my records exceeds \$_____.

PLEASE PRINT:

Name: _____ Phone #:() _____

Address: _____

Signature: _____ Date: _____