Christ Community
HEALTH SERVICES AUGUSTA

REQUEST FOR MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ ZIP: _____

Social Security Number: _____ Home Phone: _____ Cell Phone: _____

1. AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FROM:

I hereby authorize representatives from the following facility/facilities to disclose the above-named individual's health information to Christ Community Health Services Augusta as directed below:

❒ **Georgia Regents Medical Center**	❒ **University Hospital**	❒ **Doctors Hospital**	❒ **Trinity Hospital**
Tel: 706-721-2948	Tel: 706-774-2283	Tel: 706-651-2434	Tel: 706-481-7652
Fax: 706-721-7132	Fax: 706-774-8737	Fax: 706-651-6980	Fax: 706-481-7877

OR Facility Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

2. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:

❒ Complete medical record *(please specify dates of service)* _____

OR

Partial medical record *(please specify dates of service)*

	Information	Dates		Information	Dates
❒	ED Record	_____	❒	Operative Notes	_____
❒	Discharge Summary	_____	❒	Diagnostic Test	_____
❒	History and Physical	_____	❒	X-rays	_____
❒	Consult Note	_____	❒	Mammogram	_____
❒	Office Notes	_____	❒	Medical Summary	_____
❒	Lab Results	_____	❒	Colonoscopy	_____
			❒	PAP	_____

3. RECEIVING PARTY

Please send my health information/medical record to:

Christ Community Health Services Augusta
PO Box 2344, Augusta, GA 30903
Phone: 706-922-0600 Fax: 706-922-0603

I understand that this authorization is **valid for six months** unless I notify Christ Community Health Services Augusta otherwise. I may revoke this authorization in writing at any time except to the extent that Christ Community Health Services Augusta has already relied on this authorization. I may revoke it by mailing or faxing a written notice to Christ Community Health Services Augusta, to the address/fax number above stating my intent to revoke this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"): treatment for history of drug or alcohol abuse; or mental or behavioral health or psychiatric care. I understand my treatment will not be conditioned by my completion of this form. *I understand that I may be billed per the fee schedule for medical records with the exception of records directly released from Christ Community Health Services Augusta to another Professional Medical Facility.* This information will be provided in a prompt manner according to the standards of Christ Community Health Services Augusta provided all information has been supplied to Christ Community Health Services Augusta correctly. I understand that I have the right to refuse to sign this authorization.

_____ _____

Patient Signature or Personal Representative Date

_____

Print Name

As a personal representative, I have authority to act for the individual because I am: _____