Navicent Health Form

Title: Z26187 Patient Request for Access

I am a patient of Navicent Health and my information is listed below:

Patient Name: ______________________________ Date of Birth: ____________________
Street Address: ______________________________ Last 4 numbers of SSN: ____________
City, State, Zip: ______________________________ Telephone: ____________________
Email address: ____

By providing your email address, you acknowledge and accept the risks outlined in Guidelines for E-mail with Patients, posted on Navicenthealth.org.

I would like for ______________________________________ **to** **(choose one):**
(list facility or practice)

☐ **Give me a copy of my health information, or** ☐ **Send my records to:**

____
(Name of Facility, Person, Company) (Phone Number)

____
(Street Address or PO Box, City, State, Zip Code)

____
(E-mail Address) (Fax Number)

I would like these dates of service to be released: Date(s) of Service: ____/____/____ through ____/____/____

I want these parts of my record:

❑ **Entire Record**	❑ **Abstract** (Summary)	❑ **Itemized Bill**	❑ Mental Health Records
❑ History & physical	❑ Emergency Center	❑ Operative Reports	❑ Radiology Reports
❑ Consultations	❑ Health Center/Clinic	❑ Outpatient Rehab Records	❑ Urgent Care Record
❑ Discharge Summary	❑ Hospice Records	❑ Drug/Alcohol Abuse Treatment **	❑ Cardiovascular Reports
❑ Office/Progress Notes	❑ Lab/Pathology Reports	❑ Other______________________________	

**** Records protected by 42 CFR Part 2 may not be redisclosed without my additional written consent***

I want these records as a (Choose one): ☐ CD ☐ E-mail ☐ Paper Copy

I want you to send the records by (Choose one): ☐ Mail ☐ Secure E-mail ☐ Fax ______________________

☐ Prepare for pick up by:______________________

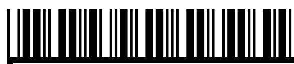
Signature: ______________________________ Print Name: ______________________________

Relationship to Patient: ______________________________ Date: ____________________

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this for the patient. (Written Proof May be Requested)

RETURN COMPLETED FORM IN PERSON, BY MAIL, BY EMAIL OR BY FAX

Email	**Mail**	**Fax**
MedicalRecordsROI@NavicentHealth.org	Navicent Health Attn: Release of Information 777 Hemlock St. MSC# 148 Macon, Georgia 31201	**(478) 633-7818**



Entity-Department Name: MCNH - HIM	**Revision Date: 7/1/2019**
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