



# Navicent Health Form



**Title: Z26187 Patient Request for Access RHNH**

**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:**

<input type="checkbox"/> <b>Entire Record</b>	<input type="checkbox"/> <b>Abstract (Summary)</b>	<input type="checkbox"/> <b>Itemized Bill</b>	<input type="checkbox"/> <b>Mental Health Records</b>
<input type="checkbox"/> <b>History &amp; physical</b>	<input type="checkbox"/> <b>Emergency Center</b>	<input type="checkbox"/> <b>Operative Reports</b>	<input type="checkbox"/> <b>Radiology Reports</b>
<input type="checkbox"/> <b>Consultations</b>	<input type="checkbox"/> <b>Health Center/Clinic</b>	<input type="checkbox"/> <b>Outpatient Rehab Records</b>	<input type="checkbox"/> <b>Urgent Care Record</b>
<input type="checkbox"/> <b>Discharge Summary</b>	<input type="checkbox"/> <b>Hospice Records</b>	<input type="checkbox"/> <b>Drug/Alcohol Abuse Treatment **</b>	<input type="checkbox"/> <b>Cardiovascular Reports</b>
<input type="checkbox"/> <b>Office/Progress Notes</b>	<input type="checkbox"/> <b>Lab/Pathology Reports</b>	<input type="checkbox"/> <b>Other _____</b>	

**\*\* 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 OR BY FAX**

<b>Mail</b> Rehabilitation Hospital NH HIM Department Attn: Release of Information 3351 Northside Dr. Macon, Georgia 31210	<b>Fax</b> 478-201-6542
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