Place label here

REQUEST FOR MEDICAL RECORDS

PART A: Patient Information (Please Print)

Patient Name: ______________________________

Date of Birth: ______________________________

Contact Number: ____________________________

Address:____________________________________

State ______________ Zip _____________________

PART B: Scope of Access Request

I request a copy of my protected health information held by: (if applicable select a CPC home location)

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I request the following protected health information

- ☐ Last 2 office notes
- ☐ Last year of lab reports
- ☐ Preventative reports to include (last colonoscopy, mammogram, dexa, diabetic eye exam)
- ☐ Last year or radiology reports
- ☐ Other ____________________________

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PART C: Manner of Access

I would like to receive my records in the following format: (if applicable select a CPC home location)

- o I wish to pick up my records
- o Please send copies of my records to:

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By signing this form, I authorize the release protected health information about me (or another person for whom I have given authority to sign) to the Center for Primary Care for the time period, purpose, and extent described above. My signature indicates that I fully understand and acknowledge the following:

- My health record may include information relating to sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, blood alcohol and drug testing, and treatment for alcohol and drug abuse.
- The protected health information to be used or disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal law.
- I have the right to refuse to sign this authorization. CPC will not condition treatment, payment, enrollment, or benefits eligibility on my signing this authorization.
- I have the right to revoke this authorization in writing at any time to the extent that the use or disclosure has not already been made. I may do so in person at the office where my records are maintained.
- CPC may charge a fee for copies of requested health information to cover cost of labor, supplies, and/or postage, if mailed to you. We will inform you of the total charges before providing the requested copies.

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Signature of Patient or Legal Representative

____

Relationship to patient (if representative)

____

Date

Central
3614-D J Dewey Gray Cir
Augusta GA 30909
(p) 706-868-7380
(f) 706-868-7223

Crossroads
1701 Magnolia Way
Augusta GA 30909
(p) 706-922-6600
(f) 706-650-0239

Evans
363 N Belair Rd
Evans GA 30809
(p) 706-650-7563
(f) 706-650-0512

Gateway
4039 Gateway Blvd
Grovetown Ga 30813
(p) 706-922-1600
(f) 706-922-1010

South
2011 Windsor Spring Rd
Augusta GA 30906
(p) 706-798-1700
(f) 706-798-8626

McDuffie
505 Mt Pleasant Rd
Thomson GA 30824
(p) 706-595-1461
(f) 706-597-9824

North Augusta
105 E Hugh Street
North Augusta SC 29841
(p) 803-279-6800
(f) 803-279-2876

Aiken
131 Rhinehart Way
Aiken SC 29801
(p) 803-335-2200
(f) 803-649-7966