Release of Information Provider for Morehouse Healthcare

To assist in properly handling your request for medical information, please complete the entire authorization form. All authorizations must be signed and dated by the patient, unless the patient is a minor child, deceased, physically, and/or mentally impaired or has an appointed Power of Attorney/Legal Guardian over healthcare. A government issued photo ID, copy of the Power of Attorney over healthcare, guardianship papers, death certificate, and/or executor papers must accompany the request.

Payment for records is not accepted at the facility and you will receive an invoice in the mail.

There are state mandated fees for copies of medical records.
State of Georgia Fee Schedule Chapter 33 of Title 31 of the Official Code of Georgia Annotated. Section 2-A

Format of Original Patient Record	Cost for delivery in electronic format (CD/USB/download or portal):	Cost for record delivered in Paper
Electronic or Hybrid (part electronic part paper)	▪ $6.50 flat fee for electronic portion ▪ Plus, if applicable, $0.07 per page for CIOX Health's labor cost to create and deliver the portion of record maintained in paper ▪ Plus sales tax as applicable	▪ $0.07 per page for CIOX Health's labor cost to create and deliver the portion of record maintained in paper ▪ Plus, if applicable, the lower of cost under state regulated patient rates or $0.90 for CIOX Health's average labor cost to create and deliver the portion of record maintained electronically ▪ Plus $0.05 per page for supplies (paper and toner) ▪ Plus actual postage if mailed ▪ Plus sales tax as applicable
Paper	▪ $0.07 per page for CIOX Health's labor cost to create and deliver the portion of record maintained in paper Plus actual postage if mailed ▪ Plus sales tax as applicable	▪ $0.07 per page for CIOX Health's labor cost to create and deliver the portion of record maintained in paper ▪ Plus $0.05 per page for supplies (paper and toner) ▪ Plus actual postage if mailed ▪ Plus sales tax as applicable

By signing below, I acknowledge that I have read the above procedures regarding the release of medical records.

PLEASE PRINT

NAME: _____ PHONE#: (_____) _____

ADDRESS:_____

CITY: _____ STATE/ZIP: _____

_____ _____

Patient Signature **Date**