Dear Patient:

BACTES Imaging Solutions, LLC, a trusted Business Associate of Savannah Neurology Specialists, is happy to assist you with your request for a copy of your medical records.

Please fill out the attached form carefully, indicating where you would like the requested information delivered. If you provide an email address we can deliver your records to you electronically through our secure edelivery process.

Please note, in order to fulfill your request, BACTES will charge a reasonable fee for copying in accordance with state law. You will be responsible for these charges.

The following fees will apply:

$.97/page for the first 20 pages,
$.83/page for 21 thru 100 pages,
$.66/page for excess of 100 pages, plus postage, up to a "flat fee" of $25.00 for a 2 year abstract or $45.00 for a 5 year abstract

After you submit your request, you'll receive notification from BACTES regarding payment options. Once payment is received, records will be mailed to you.

For Records being sent to Another Health Care Provider

Please provide as much contact information for your other Doctor, including the address, phone & fax. There is no charge for records delivered to another healthcare provider for ongoing treatment purposes.

You can contact our BACTES representative by calling (912) 354-7676 ext 6483

Authorization to Disclose Protected Health Information
The undersigned authorizes
Savannah Neurology Specialists
6602 Waters Avenue Bldg C• Savannah, GA 31405
Ph. 912-354-7676 • Fx. 912-354-7181
to release my health information as noted below:

Patient Information

Patient Full Name: _____ **Other Names?** _____

Patient Address: _____ **Date of Birth:** _____

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information To

Name/Facility: _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ State: _____ Zip: _____ **Fax #:** _____

Email: _____ *(Patient's Only – Please ensure email address is legible!)*

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other:_____

Please forward Records by: ☐ Mail ☐ Fax (for Dr's Offices) ☐ Email (For Patients)

Information to be Released

If you fail to specify, a 1 year abstract will be provided.

☐ Please release a **1 year** abstract of my records (includes most recent notes, labs, & testing)
☐ Please release a **2 year** abstract of my records
☐ Please release my **entire record**.
☐ **Other** (please specify): _____
_____

I understand I will be responsible for the charges incurred in the release of my protected health information. *See GA Code §31-33-3*
Copy fee: $0.97 per page for pages 1-20 / $0.83 per page for pages 21-100 / $0.66 per page, thereafter / Postage, if applicable
Records being sent to another healthcare provider will be provided at no cost.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ *(Please Initial)*

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.** *If I do not specify expiration this authorization will expire in 90 days.*
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*:_____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*