



Welcome and thank you for choosing to become a patient of our practice. We will work diligently to ensure that you receive the best care available. We would like to take this opportunity to familiarize you with our office policies:

The following is a list of what is necessary to bring to your first visit:

- Insurance Card(s) and picture ID
- The names, phone and fax numbers to your previous doctors to obtain your medical records.
- The enclosed forms filled out and signed.
- **All medications you are currently taking in the bottles.**
- The NEW PATIENT paperwork. (Please BRING TO YOUR APPOINTMENT)

**OFFICE HOURS: Monday - Friday from 7am to 5pm**

### Reminders:

- It is your responsibility to know the benefits that you receive from your insurance company. This includes wellness/physical coverage, deductible amounts, and co-payment requirements.
- We use QUEST lab for all lab work. If your insurance requires a different company to be used, it is your responsibility to tell us before labs are drawn so that you may be given an order sheet to go to an outside lab that insurance covers.
- In compliance with HIPPA laws, no information will be given to anyone, including family, without prior written consent.
- New Patients will only be allowed to reschedule or cancel their initial appointment twice. Failure to contact the office to cancel or reschedule new patient appointment will result in Dismissal from the practice and unable to return.
- If your insurance company contacts you requesting information to process a claim, please contact them to prevent the bill from becoming your responsibility.
- To ensure patient care is not interrupted during the day, all calls for the Providers will be directed to the nurses.
- We provide same day and walk in appointments for our established patients.

Our goal is to provide you with the most efficient and up to date health care available. We are always open to suggestions. We look forward to seeing you!

Sincerely,  
Dr. Mary Bell Vaughn and  
Vineville Internal Medicine Staff

Your Appointment is  
Scheduled on: \_\_\_/\_\_\_/\_\_\_ at \_\_\_:\_\_\_ with

#### **Building A---BLUE BALLOONS**

- Erin Caves       Cherrice Clay-Austin  
 Ashley Dykes     Dr. Mary Bell Vaughn

#### **Building B---GREEN BALLOONS**

- Ronda Toole       Shandora Hayman-Jones  
 Lauren Lambeth     Dr. James Thigpen

#### **Building C---YELLOW BALLOONS**

- Dr. Daryl Remick



Be sure to like us on Facebook



and Instagram @ vinevilleinternalmedicine



Mary Bell Vaughn, MD

**3448 Vineville Ave**  
**Macon, Ga 31204**

**Coming from I-75 South:**

Get off at Hardeman Ave./Forsyth exit. Go straight through the first red light. Turn left at second red light onto Hardeman Ave. Go 2.3 miles. Turn left onto Prentice Place and turn right into the back-parking lot.

**Coming from I-75 North:**

Get off at Hardeman Ave. exit. Turn right at the first red light. Go 2.3 miles. Turn left onto Prentice Place and turn right into the back-parking lot.

**Coming from Forest Hill Rd:**

Turn left onto Vineville Ave, at the Forest Hill/Park St. Intersection. Go straight past Walgreen's and turn on the 6<sup>th</sup> street on the right called Prentice Place. Turn right into the back-parking lot.

**Coming from Zebulon Rd:**

Take Zebulon Rd. to Forsyth Rd. Turn right. Go approx. 2.4 miles to the Forest Hill/Park St. intersection. Go straight past Walgreen's and turn on the 6<sup>th</sup> street on the right called Prentice Place. Turn right into the back-parking lot.



PATIENT INFORMATION:			
Last Name:	First Name:	MI:	Marital Status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Mailing Address:		Race (check one): <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Other	
City:	State:	Zip Code:	
Email:	Cell Phone: (primary) ( )	Home Phone: ( )	<b>Appointment Reminders</b> <input type="checkbox"/> Text <input type="checkbox"/> Call
Date of Birth:	Sex (Check One) <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number: - - -	
Employer:	Occupation:	Employer Phone: ( )	
IN CASE OF EMERGENCY:			
Name:	Relationship to Patient:	Cell Number: ( )	Home Number: ( )
HEALTH INFORMATION DISCLOSURE:			
List anyone that may call on your behalf or pick up any prescription if you are unable to do so <input type="checkbox"/> <b><u>Check if you DO NOT want your emergency contact or anyone else to have HID access</u></b>			
Name / Phone Number	1. / ( )	2. / ( )	
3. / ( )	4. / ( )		
INSURANCE INFORMATION:			
<b>1. <u>Name of Primary Insurance:</u></b>		Subscriber's SSN: (if different from patient)	
Subscriber's Name: (if different from patient)		DOB:	
ID/Policy Number:		Group Number/Plan Code:	
Patient's Relationship to Subscriber: <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other			
<b>2. <u>Name of Secondary Insurance: (if Applicable)</u></b>		Subscriber's SSN: (if different from patient)	
Subscriber's Name: (if different from patient)		DOB:	
ID/Policy Number:		Group Number/Plan Code:	
Patient's Relationship to Subscriber: <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other			
<b>3. <u>Other Insurance:</u></b>		ID/Policy Number:	Group Number/Plan Code:
The above information is true to the best of my knowledge. I hereby authorize direct payment to my physicians from my insurance company when applicable. I understand that I am responsible for any balance(s) not paid by my insurance carrier and is to be paid to VIM. Said balance is to be paid in a timely manner. I also authorize the release of any medical information to a referring physician or insurance company. <b>Gracie provides health information in a secure, electronic format allowing healthcare professionals to appropriately access and securely share a patient's health information electronically through EHR system. If you would like to opt out, please let the front desk know and they will give you a form to complete.</b>			
<b>Patient/Guardian Signature:</b> _____			<b>Date:</b> ___/___/___

**Patient Name:** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Age** \_\_\_\_\_ **DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Date of Last Physical** \_\_\_\_\_

**Reason for your visit today** \_\_\_\_\_

Conditions & Symptoms (Check the conditions or symptoms you currently have or have had in the past year)

<u>General</u>	<u>Gastrointestinal</u>	<u>Ophthalmology</u>	<u>Skin</u>
<u>Specialists:</u> <input type="checkbox"/> Appendicitis <input type="checkbox"/> Chills <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Hernia <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Organ Transplant <hr/> <input type="checkbox"/> Ulcers <input type="checkbox"/> Sweats <input type="checkbox"/> Measles <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pollo <b><u>Muscle/Joint/Bone</u></b> <u>Specialist:</u> Pain, weakness or numbness in: <input type="checkbox"/> Arms <input type="checkbox"/> Back <input type="checkbox"/> Feet <input type="checkbox"/> Hands <input type="checkbox"/> Arthritis <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Neck <input type="checkbox"/> Shoulders <b><u>Infectious Diseases</u></b> <u>Specialist:</u> <input type="checkbox"/> AIDS <input type="checkbox"/> HIV Positive <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Venereal Disease <b><u>Pulmonary</u></b> <u>Specialist:</u> <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <b><u>Endocrinology</u></b> <u>Specialists:</u> <input type="checkbox"/> <u>Diabetes</u> <input type="checkbox"/> <u>Goiter</u> <input type="checkbox"/> <u>Thyroid Problems</u>	<u>Specialists:</u> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel Changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver Disease <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <b><u>Psychiatric</u></b> <u>Specialists:</u> <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anorexia <input type="checkbox"/> Bulimia <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Depression <input type="checkbox"/> Nervousness <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Suicide Attempt <b><u>Hematology/Oncology</u></b> <u>Specialists:</u> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Cancer <b><u>Rheumatology</u></b> <u>Specialists:</u> <input type="checkbox"/> Gout <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <b><u>Nephrology</u></b> <u>Specialists:</u> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Dialysis Treatment	<u>Specialists:</u> <input type="checkbox"/> Cataracts <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Vision-Flashes <input type="checkbox"/> Vision-Halos <b><u>Cardiovascular</u></b> <u>Specialists:</u> <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart Disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Pacemaker <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins <b><u>Neurological</u></b> <u>Specialists:</u> <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Numbness <input type="checkbox"/> Epilepsy <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Stroke <b><u>Ear, Nose &amp; Throat</u></b> <u>Specialists:</u> <input type="checkbox"/> Allergies <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Tonsillitis	<u>Specialists:</u> <input type="checkbox"/> Acne <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Redness <input type="checkbox"/> Scars <input type="checkbox"/> Sores that will not heal  <b><u>Genito-Urinary</u></b> <u>Specialists:</u> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Herpes <b><u>MEN only</u></b> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Dore on penis <input type="checkbox"/> Other <b><u>WOMEN only</u></b> <input type="checkbox"/> Abnormal Pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Miscarriage <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Other  <b><u>Date of Last:</u></b> Menstrual period _____ Pap smear _____ Mammogram _____ Chest x-ray _____ Echo _____ Colonoscopy _____

**Patient History (fill in health information about yourself)**

**Current Prescriptions Medications**

Name of Drug	Dosage in Milligrams	# of tablets	# Times taken per day	Prescribing Physician

**Current OTC Medication (this includes vitamins and Herbal treatments)**

Name of Drug	Dosage in Milligrams	# of tablets	# Times taken per day	Prescribing Physician

**Allergies (reaction-hives, swelling, nausea/type-allergy, side effect, lack of therapy/status-active, inactive)**

Name of Drug/Food	Reaction	Type	Status

**Previous Medications Taken (i.e. blood pressure-nontherapeutic/cannot tolerate satins)**

Name of Drug	Dosage in Milligrams	Reason No Longer Taking

Patient Name:

**Family History (fill in health information about your family)**

Relation	Age	State of health	Age of Death	Cause of Death	Check if, your blood relative had any of the following	
					Disease	Relationship to you
Father					<input type="checkbox"/> Arthritis, Gout	
Mother					<input type="checkbox"/> Asthma, Hay Fever	
Brothers					<input type="checkbox"/> Cancer	
					<input type="checkbox"/> Chemical Dependency	
					<input type="checkbox"/> Diabetes	
					<input type="checkbox"/> Heart Disease	
Sisters					<input type="checkbox"/> High Blood Pressure	
					<input type="checkbox"/> Kidney Disease	
					<input type="checkbox"/> Tuberculosis	
					<input type="checkbox"/> Stroke	

**Hospitalizations/Operations**

Year	Hospital	Reason for hospitalization and outcome

Have you ever had a blood transfusion? ( ) yes ( ) no

If yes, please give approximate date \_\_\_\_\_

Serious illness/injuries	Date	Outcome

**Pregnancies**

Year of birth	Sex of birth	Complications?

**Health Habits**

(Check which you use or do and describe how much you use)

( ) Caffeine	
( ) Tobacco	
( ) Regular Exercise	
( ) Soda	
( ) Raw Fruit	
( ) Vegetables	
( ) Alcohol	
( ) Fiber	

**Immunizations**

Vaccine	Date Given
Tetanus/Tdap	
Pneumovax (pneumonia)	
Flu	
Gardasil (HPV)	
Varicella (chicken pox)	
Meningococcal	
Hepatitis A	
Hepatitis B	
Zostavax (shingles)	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her practice responsible for any errors or omissions that I may have made in the completion of this form

Signature:

Date: \_\_\_/\_\_\_/\_\_\_

Rooming Nurse: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_



Mary Bell Vaughn, MD

## Patient Financial Policy

In order to take preventative measures and help reduce misunderstandings; we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. Unless other arrangements have been made in advance by your health insurance carrier:

- All co-pays and deductibles are due at the time of the visit.
- Additional financial responsibility may be determined after your insurance has processed your claim.
- For your conveniences we accept Visa, MasterCard, Discover, American Express, Cash and Checks.
- Checks returned for NSF will incur a \$30.00 fee which will be added to our account balance.

### Patient Insurance

We have made prior arrangements with many insurers and health plans to accept assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. Our office policy is to collect this co-payment when you arrive for your appointment, or you may be subject to a finance processing fee \$10, for charging your required co-payment. If you have insurance coverage with a plan that we do not have a prior agreement with, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service. If your health plan determines a service to be "not covered," you will be responsible for the complete charge. Should any test performed result with any abnormalities, additional testing may be required-and will fall under the patients' responsibility for those charges.

### Minor Patients

For all services rendered to minor patients. We will look to the adult accompanying the patient and the parent or guardians with custody for payment.

All patient under the age of 18 will not be seen without a parent or guardian present/or without signed consent form.

### Self-Pay Patients

For all services rendered to patients without insurance or proper proof of insurance, a self-pay discounted charge will be applied to your account. Payment is due at the time of services rendered unless previous arrangements have been made with the billing office. Should any test performed result with any abnormalities, additional testing may be required-and will fall under the patients' responsibility for those charges. Payment is due upon receipt of all statements from out office.

### Account Balance

All patient balances must be paid in full when statement is received. Failure to pay a minimum of 20% of the statement balance will make your account subject to collections with the collection agency of Vineville Internal Medicine's choosing. If your account is turned over to collection agency, you will be responsible for the collection fee of 30% that the agency charges. Any other fee incurred pursuing with the courts will also be your responsibility.

- If your account is sent to collections, you will be **dismissed** from the practice for lack of payment.

### Patient Agreement:

I have read and fully understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Patient Name Printed: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient/Responsible Party **Signature:** \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Policy effective date:** 01/ 01/ 2019



Vineville  
Internal  
Medicine

Mary Bell H Vaughn, MD

## Missed Appointment Fee Policy & Fee Schedule

In order to take preventative measures and to help reduce misunderstandings between our patients and practice, we have adopted the following fee schedule. If you have any questions regarding this policy please discuss them with our office manager.

The following fees are fees billed directly to the patient that are not covered by insurance. There fees are administrative fees, and must be paid at the time the request is made.

- FMLA paperwork: \$50.00 (Next Day: \$75.00 – Rush fee)
- Disability Forms: \$25.00
- Handicap Parking permits: \$10.00
- Miscellaneous Letters Written: \$15.00
- Miscellaneous Forms (simple): \$15.00
- Miscellaneous Forms (complex): \$25.00
- Medical Records in accordance with GA Laws O.C.G.A 31-33-3

### Effective July 1, 2014

Search, Retrieval, and Other Direct Administrative Costs	Up to	\$25.88
Certification Fee	Up to per record	\$9.70
Copying Costs for Records in Paper Form	Per page for pages 1-20	\$0.97
	Per page for pages 21-100	\$0.83
	Per page for pages over 100	\$0.66
<b>Note – Rates do not apply to records requests necessary to make or complete an application for disability benefits program.</b>		

Each time a patient misses an appointment without providing proper notice another patient is prevented from receiving care. Our system is set to call and/or text your reminders of your scheduled appointment. Due to high patient demand and limited availability of appointments we have instituted a “missed appointment” fee.

**You must give 24-hour advance notice to cancel or reschedule appointments; failure to do so will result in a “missed appointment” fee charge of \$50 to your account.**

**Patient Agreement:** I have read and fully understand the fee schedule of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

Patient Name (please print): \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_\_\_

Patient/Responsible Party **Signature:** \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_\_





# CENTRAL GEORGIA HEALTH EXCHANGE

*The next generation of patient information*

## Permission to Create a Health Exchange record and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this permission form*.

**Yes, I AGREE** to participate in the Central Georgia Health Exchange electronic medical record

**No**, I do not wish to participate in the Central Georgia Health Exchange electronic medical record at this time

/ /	/ /	/ /	/ /
<b>Printed Name of Patient/Representative</b>	<b>DOB</b>	<b>Signature</b>	<b>Date</b>

**AUTHORITY OF REPRESENTATIVE:** POA

I, \_\_\_\_\_ do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: Relationship to Patient: \_\_\_\_\_

[A signed copy of this permission will be provided to the patient representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the Health Exchange electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The Health Exchange v II allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the Health Exchange to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization. Confinement, diagnosis or other information concerning my physical or mental condition. Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to re-disclosure. However, the Health Exchange system incorporates access controls. Encryption technology and other security features designed to protect the privacy and security of your Health information. In addition, Access to the Health Exchange will be limited to only those users who have agreed to use the Health Exchange consistent with your permission. Information shared through the Health Exchange will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the Health Exchange and CGHN.

You can learn more about the Central Georgia Health Exchange by reading the information booklet, "A Guide to the Central Georgia Health Exchange" that is available at the CGHE website (<https://www.CGHE.net>) or on request from your healthcare provider's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange, 111 Perimeter Parkway Macon, GA 31210. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the Central Georgia Health Exchange program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to my other healthcare providers (including, but not limited to, participating Emergency Rooms, Urgent Care Centers, Hospitals, Surgery Centers, and Doctors' Offices) through the Central Georgia Health Exchange.



Vineville  
Internal  
Medicine

Mary Bell H. Vaughn, MD

## Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/facility listed below.

Patient Name: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_

Records being requested from:

Dr. _____	Phone Number: _____	Fax Number: _____
Dr. _____	Phone Number: _____	Fax Number: _____
Dr. _____	Phone Number: _____	Fax Number: _____
Dr. _____	Phone Number: _____	Fax Number: _____

The information you may release subject to this signed release form is as follows:

- |  |   |   |
|--|---|---|
| <input checked="" type="checkbox"/> Complete Records ( <b>last 2 years</b> ) | <input type="checkbox"/> Lab Reports      | <input type="checkbox"/> Pathology Reports    |
| <input type="checkbox"/> Progress Notes                                      | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> H&P   | <input type="checkbox"/> Rx Records       | <input type="checkbox"/> Hospital Reports     |
| <input type="checkbox"/> Other (Please specify below)                        |   |   |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(ONLY if this applies to you)**

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. If this applies,

Please initial and date this form. Initial: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Release my protected health information to the following physician/facility:

Dr. Mary Bell Vaughn  
Vineville Internal Medicine  
3448 Vineville Ave  
Macon, Ga 31204

Phone: 478-405-0045  
**Fax: 478-405-0054**

Patient Name (Please Print) \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_