

 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 - Thursday from 8:30am 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!

|  |
| --- |
| Your Appointment isScheduled on: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ at \_\_\_: \_\_\_\_\_ with( ) Kim Johnson ( )Dr. Mary Bell Vaughn |

Sincerely,

Dr. Mary Bell Vaughn and

Vineville Internal Medicine Staff

 **Be sure to like us on Facebook**

and Instagram @ vinevilleinternalmedicine

1024 Keith Drive \* Perry, Ga 31069 \* Phone: 478-405-0045 \* [www.vinevilleinternalmedicine.com](http://www.vinevilleinternalmedicine.com)

  Mary Bell Vaughn, MD

**1024 Keith Drive**

**Perry, GA 31069**

**Coming from I-75 South:**

 Get off of I-75 S at Exit 138, Thompson Rd/Perry Pkwy, turn left onto Perry Pkwy. Continue on Perry Pkwy through the first red light. Turn right at the second red light onto Houston Lake Road. In 0.5 miles, turn left onto Keith Drive. Go straight through the 4-way. In approximately 0.5 miles, turn left into parking lot.

**Coming from I-75 North:**

 Get off of I-75 N at Exit 135 and turn right. Turn left onto General Courtney Hodges Blvd (first red light). In 1.1 miles, turn right onto Main Street. Turn left after 1.9 miles onto Keith Drive. After 0.3 miles, turn right into parking lot.

**Coming from Hawkinsville(Taylor Regional Hospital):**

 Take a right on US-341 N /Golden Isles Pkwy. In 11 miles, turn right onto US-341 N/Main Street. After 7.2 miles, turn right onto Keith Drive. After 0.3 miles, turn right into parking lot.

1024 Keith Drive Perry, Ga 31069 Phone: 478-405-0045 \* [www.vinevilleinternalmedicine.com](http://www.vinevilleinternalmedicine.com)

|  |
| --- |
| **PATIENT INFORMATION:** |
| Last Name: | First Name: MI: | Marital Status (check one)( ) Single ( ) Married ( ) Divorced ( ) Separated ( )Widowed |
| Mailing Address: | Race (check one):( )Black/African American ( ) White( ) Hispanic ( )Other |
| City: | State: | Zip Code: |
| Email: | Cell Phone: (primary)( ) | Home Phone:( ) | **Appointment Reminders**( ) Text ( ) Call |
| Date of Birth: | Sex (Check One)( ) Male ( ) 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**( ) Check if you DO NOT want your emergency contact or anyone else to have HID access** |
| Name / Phone Number | 1. / ( ) | 2. / ( ) |
| 3. / ( ) | 4. / ( ) |
| **INSURANCE INFORMATION:** |
| **1. Name of Primary Insurance:** | 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: ( ) Child ( ) Self ( ) Spouse ( ) Other |
| **2. Name of Secondary Insurance: (if Applicable)** | 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: ( ) Child ( ) Self ( ) Spouse ( ) Other |
| **3. Other Insurance:** | 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. **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.** |
| **Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_** |

 

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
|  **General**Specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Appendicitis
* Chills
* Chicken Pox
* Dizziness
* Fainting
* Fever
* Hernia
* Loss of sleep
* Loss of weight
* Organ Transplant
* Ulcers
* Sweats
* Measles
* Mononucleosis
* Mumps
* Pollo

 **Muscle/Joint/Bone**Specialist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pain, weakness or numbness in:* Arms
* Back
* Feet
* Hands
* Arthritis
* Hips
* Legs
* Neck
* Shoulders

 **Infectious Diseases**Specialist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* AIDS
* HIV Positive
* Typhoid Fever
* Venereal Disease

**Pulmonary**Specialist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Bronchitis
* Emphysema
* Tuberculosis
* Pneumonia
* Asthma

**Endocrinology**Specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Diabetes
* Goiter
* Thyroid Problems
 |  **Gastrointestinal**Specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Appetite poor
* Bloating
* Bowel Changes
* Constipation
* Diarrhea
* Excessive hunger
* Excessive thirst
* Gas
* Hemorrhoids
* Hepatitis
* Liver Disease
* Indigestion
* Nausea
* Rectal Bleeding
* Stomach pain
* Vomiting
* Vomiting blood

**Psychiatric**Specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Alcoholism
* Anorexia
* Bulimia
* Chemical Dependency
* Depression
* Nervousness
* Psychiatric Care
* Suicide Attempt

**Hematology/Oncology**Specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Anemia
* Bleeding disorders
* Cancer

**Rheumatology**Specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Gout
* Rheumatic Fever
* Scarlet Fever

**Nephrology**Specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Kidney Disease
* Dialysis Treatment
 |  **Ophthalmology**Specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Cataracts
* Crossed eyes
* Blurred vision
* Double vision
* Glaucoma
* Vision-Flashes
* Vision-Halos

 **Cardiovascular**Specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Chest pain
* Heart Disease
* High blood pressure
* High Cholesterol
* Irregular heart beat
* Low blood pressure
* Pacemaker
* Poor circulation
* Rapid heart beat
* Swelling of ankles
* Varicose veins

**Neurological**Specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Forgetfulness
* Headache
* Numbness
* Epilepsy
* Migraine Headaches
* Multiple Sclerosis
* Stroke

**Ear, Nose & Throat**Specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Allergies
* Bleeding gums
* Difficulty swallowing
* Earache
* Ear discharge
* Hay fever
* Hoarseness
* Loss of hearing
* Nosebleeds
* Persistent cough
* Ringing in ears
* Sinus problems
* Tonsillitis
 |  **Skin**Specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_* Acne
* Bruise easily
* Hives
* Itching
* Change in moles
* Rash
* Redness
* Scars
* Sores that will not heal

**Genito-Urinary**Specialists:\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Blood in urine
* Frequent urination
* Lack of bladder control
* Painful urination
* Gonorrhea
* Herpes

**MEN** only* Breast lump
* Erection difficulties
* Lump in testicles
* Penis discharge
* Prostate Problems
* Dore on penis
* Other

**WOMEN** only* Abnormal Pap smear
* Bleeding between periods
* Breast lump
* Extreme menstrual pain
* Hot flashes
* Miscarriage
* Nipple discharge
* Painful Intercourse
* Vaginal discharge
* Vaginal Infections
* Other

**Date of Last:**Menstrual period \_\_\_\_\_\_\_\_\_Pap smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mammogram \_\_\_\_\_\_\_\_\_\_\_\_Chest x-ray \_\_\_\_\_\_\_\_\_\_\_\_\_\_Echo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Colonoscopy \_\_\_\_\_\_\_\_\_\_\_\_ |

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  Name of Drug |  Dosage in Milligrams | # of tablets | # Times taken per day | Prescribing Physician |
|  |  |  |  |  |
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**Allergies (reaction-hives, swelling, nausea/type-allergy, side effect, lack of therapy/status-active, inactive)**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Drug/Food |  Reaction |  Type |  Status |
|  |  |  |  |
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**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 followingDisease Relationship to you |
| Father |  |  |  |  |  Arthritis, Gout |  |
| Mother |  |  |  |  |  Asthma, Hay Fever |  |
| Brothers |  |  |  |  |  Cancer |  |
|  |  |  |  |  |  Chemical Dependency |  |
|  |  |  |  |  Diabetes |  |
|  |  |  |  |  Heart Disease |  |
| Sisters |  |  |  |  |  High Blood Pressure |  |
|  |  |  |  |  |  Kidney Disease |  |
|  |  |  |  |  Tuberculosis |  |
|  |  |  |  |  Stroke |  |

**Hospitalizations/Operations** **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) |  |

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| --- | --- | --- |
| Year | Hospital | Reason for hospitalization and outcome |
|  |  |  |
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| Have you ever had a blood transfusion? ( ) yes ( ) noIf yes, please give approximate date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Serious illness/injuries | Date | Outcome |
|  |  |  |
|  |  |  |
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|  |
| --- |
| **Pregnancies** |
| Year of birth | Sex of birth | Complications? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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 you 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 pursing 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/ 2022

 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
* Medication Prior Auth. Paperwork: $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 |
| **Note – Rates do not apply to records requests necessary to make or complete an application for disability benefits program.** |

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

 **Printed Name of Patient/Representative *DOB* Signature *Date***

*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 you’re 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) ll1roughthe *Central Georgia Health Exchange.*

1204

 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:

(**X**) Complete Records (**last 2 years**) ( ) Lab Reports ( ) Pathology Reports

( ) Progress Notes ( ) Radiology Report ( ) Immunization Records

( ) H&P ( ) Rx Records ( ) Hospital Reports

( ) Other (Please specify below)

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**(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 Phone: 478-405-0045

Vineville Internal Medicine **Fax: 478-405-0054**

3448 Vineville Ave

Macon, Ga 31204

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

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