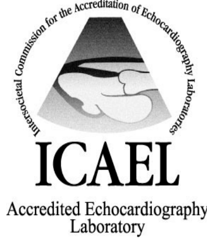
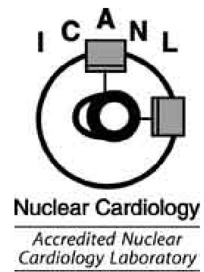


William M. Hudson, M. D., F.A.C.C., P.C.
Cardiovascular Medicine
110 Samaritan Drive
Suite 101
Cumming, GA 30040



OFFICE POLICY FOR RELEASE OF INFORMATION

Please be advised that effective May 1, 2023, the policy for the release of medical records from the office of Dr. William M. Hudson is as follows:

Transfer to Another Healthcare Provider

- Free of charge

Patient Requests

There will be a charge to patients who request copies of their medical records for their own personal use. This charge is to create and deliver the portion of record maintained in paper format. The charge for this service will be:

Format of Original Patient Record	Cost for record delivered in Paper
Paper	• $25.88 Administrative Fee • Plus copying costs per page for cost to create and deliver the portion of record maintained in paper as indicated below: • Coping cost per page (1 – 20 pages) $0.97 • Coping cost per page (21 – 100 pages) $0.83 • Coping cost per page (100+ pages) $0.66 • Plus applicable postage if mailed

- Once copied, you will be pre-billed by our office, and your records will be sent once payment is received. We only accept checks and money orders payable to William M. Hudson, MD, PC
- These fees are pursuant to O.C.G.A §31-33-3 state guidelines from July 2022 and are subject to change at anytime
- Medical records will only be mailed via trackable courier, and the shipping fee will be the responsibility of the patient
- If you haven't been seen in the last 3 years from today's date, your chart may be stored offsite and is subject to retrieval. Please allow 30 days to process these requests
- Medical records may be securely transferred offsite or to a third-party medical records management company at any time

Attorney and Insurance Requests

There will be a charge for copies of your medical records, when patients authorize the release of such information to insurance companies, attorney offices, etc. Patients will not be responsible for these charges. The requestor will receive an invoice from our office.

Any request for medical records must have a completed release of information form **(see the back of this form)**. Only completed and signed forms will be processed. Any information will cause a delay.

Please send your completed release of information form **ALONG WITH THE FEE AS DIRECTED BY OUR OFFICE** by mail to:
Dr. William M. Hudson, MD, PC
110 Samaritan Drive, Suite 101
Cumming, Georgia 30040

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION:				
PATIENT NAME – LAST		FIRST		MIDDLE INITIAL
DATE OF BIRTH	EMAIL	PHONE NUMBER		
ADDRESS		CITY	STATE	ZIP

RELEASE INFORMATION FROM:		RELEASE INFORMATION TO:
Provider:	William M. Hudson, M.D.	Name:
Address:	110 Samaritan Drive, Suite 101	Address:
City, State, Zip:	Cumming, Georgia 30040	City, State, Zip:
Phone:	(770) 887-0472	Phone:
Fax:	(770) 887-1140	Fax:
Attention:	Release of Information	Attention:

INFORMATION TO BE RELEASED:		
☐ **Complete Medical Record**		
☐ **Partial Medical Record – specified below** from date(s) of service		
☐ History and Physical	☐ Lab Reports	☐ Cardiac Testing
☐ Consultation Notes	☐ EKG/Cardiology Reports	☐ Radiology Reports
☐ Discharge Summary	☐ Operative Reports	☐ Radiology Images
☐ Progress Notes	☐ Cardiac Catheterization Report	☐ Cardiac Intervention [PCI] Report
☐ Other (describe in detail) ______		

PURPOSE OF RELEASE:		
☐ Continuation of Care	☐ Transfer of Care	☐ Other (specify): ______

METHOD OF DELIVERY:			
☐ Pick Up	☐ Fax *to number listed above*	☐ Mail *to address listed above*	☐ Other (specify): ______

Patient's Signature: ______ Date: ______

OR Signature of Authorized Representative: ______ Date: ______

Print Name of Authorized Representative: ______

Please send your completed release of information form **ALONG WITH THE FEE AS DIRECTED BY OUR OFFICE** by mail to:

Dr. William M. Hudson, MD, PC
110 Samaritan Drive, Suite 101
Cumming, Georgia 30040

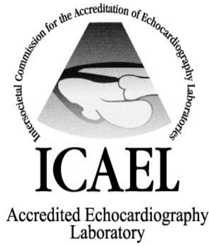
OFFICE USE ONLY:

Date Received: ______ Received By: ______

Date Released: ______ Released By: ______

☐ Records Faxed ☐ Records Mailed ☐ Records Picked Up by Patient/Patient Representative

Patient's Signature: ______ Date: ______



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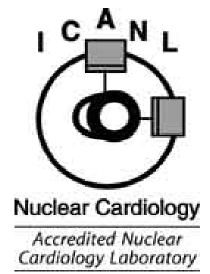

OR Signature of Authorized Representative: ___________________________________ Relationship: _______________________

Telephone: 770.887.0472 ❧ *Facsimile: 770.887.1140*