Information About Your Medical Record Request

Dear Patient,

This facility has partnered with CIOX Health, the nation's largest provider of release of medical information services, to process and fulfill your request for a copy of your medical record.

A CIOX Health client services representative digitally captures your protected health information from the facility's medical record through our confidential, secure technology platform. Your medical record information is then digitally transmitted to our Release of Information Processing Center, where it is packaged and mailed or electronically delivered to you, via our eDelivery functionality, all in a HIPAA-compliant format.

Due to the strict procedural and highly regulated steps involved in this process, known as the release of information process, there are costs associated and, therefore, a fee is charged for this service.

$0.36 per page/image for pages/images 1-200
$0.12 per page/image for pages/images 201 +
$400 maximum fee

While CIOX Health is under contract with this facility to provide release of information services, we are also committed to providing you with your requested medical record in an efficient and highly secure manner. We want to make sure you understand the process in which your records are provided and the costs associated with obtaining them.

Please don't hesitate to contact us at 800.367.1500 if you have any questions about the services CIOX Health provides on the facility's behalf, or about the bill you may receive as a result of your request for medical records.

Thank you,
CIOX Health

The fee should be remitted to HealthPort Technologies as directed on the invoice you receive.
Payment can be accepted in the following forms:

Checks are also acceptable and should be made payable to HealthPort.
Patients may also pay for their invoices online at **www.healthportpay.com**.

Acknowledgement of Medical Record Request Processing Fee

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows a fee (whether regulatory or statutory) to be associated with medical record request processing, excluding those that are needed for continuing care purposes.

This facility has partnered with CIOX Health to process and fulfill your request for a copy of your medical record. The fee charged is detailed below:

$0.36 per page/image for pages/images 1-200
$0.12 per page/image for pages/images 201 +
$400 maximum fee

By signing below, I acknowledge that I am aware of the fee that will be billed to me for requesting a copy of my medical record. I agree to pay this fee when services are rendered and I receive an invoice from HealthPort Technologies.

Name: _____Phone #:_____

Address: _____
Street City State Zip

Patient Signature: _____Date:_____
(or authorized representative)

If you would like to receive records electronically please provide email address:

_____

The fee should be remitted to HealthPort Technologies as directed on the invoice you receive.

Please note that there is no fee for medical record requests sent directly to a physician or healthcare facility for continuing care purposes.

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Cynthia Yew, FNP-BC
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Authorization for Release of Medical Information

Print Patients Full Name _____ Date of Birth _____

Street Address _____ Social Security Number _____

City/State/Zip Code _____ Home Phone Number _____

At the request of, I_____ do hereby authorize to release the following:
(check all that applies)

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ Laboratory Reports
- ☐ Radiology Reports
- ☐ Emergency Reports
- ☐ Genetic Data Reports
- ☐ Other: _____

☐ I do ☐ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, sexual transmitted infections, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

I HEREBY AUTHORIZE THE RELEASE OF RECORDS FROM: _____
_____
_____

PLEASE RELEASE INFORMATION TO: _____
_____
_____

PURPOSE OF DISCLOSURE:

- ☐ Referral to Specialist
- ☐ Legal Investigation
- ☐ Other (please specify) _____
- ☐ Insurance
- ☐ Personal
- ☐ Workers Comp
- ☐ Continuing Care
- ☐ Change of Doctor/Provider
- ☐ Disability Determination

Please provide the best telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of Individual, Guardian or Legal Representative **Date**

Print Reset