Navicent Health Form

Title: Z26167 Authorization to Release Medical Information

Patient Name:_____ Last 4 digits of SSN:_____ DOB: _____

Previous Name, if applicable:_____

Address:_____ City:_____ State: _____ Zip _____

Phone #:_____ Work #:_____

Email address_____

1. **Navicent Health Healthcare Facility/Facilities:** I authorize representatives from the following facility/facilities to disclose the health information as directed below **(Check one or more):**

❑ Medical Center	❑ Wound Care	❑ Home Health
❑ Children's Hospital	❑ Urgent Care Zebulon	❑ Pine Point Hospice
❑ Rehabilitation Hospital	❑ Urgent Care Riverside	❑ Family Health Center
❑ Medical Center of Peach County	❑ Urgent Care Gray Highway	❑ Central Georgia Family Medicine

❑ Clinic/Physician Practice (specify) _____

2. **Receiving Party:**
   - ❑ Patient. I am requesting a copy of my own record.
   - ❑ Please provide a copy of my Health Information to:

   Name:_____

   Address:_____

   City: _____ State: _____ Zip Code: _____

   Telephone #: _____ Fax # (healthcare provider only): _____

   ❑ I authorize _____ to pick up my medical records in person.
   (Name of person authorized to receive)

3. **How would you like the Health Information to be released?**
   Format: ❑ Paper Copy ❑ Electronic Copy
   Delivery: ❑ US Mail ❑ Pick-up ❑ eDelivery (Ciox Portal) ❑ CD

4. **Description of Health Information to Be Disclosed:**

   ❑ Treatment dates from _____ to _____ (Please be specific) **OR** ❑ All Treatment dates

   - ❑ **Complete medical record**
   - ❑ **Abstract:** History & Physical, Consultations, Discharge Summary, Operative Report, Lab Reports, Radiology Reports, Other Diagnostic Reports, Emergency Center Physician Dictation
   - ❑ **Continuity of Care:** Diagnostic Test Results, Problem List, Medication Lists, Medication Allergies, Discharge Summary, Procedures
   - ❑ **Partial Medical Record** *(Please specify records below)*
   - ❑ **You must check this box if you are also requesting Billing Records**

❑ History & physical	❑ Emergency Center	❑ Operative Reports	❑ Radiology Reports
❑ Consultations	❑ Health Center/Clinic	❑ Outpatient Rehab Records	❑ Urgent Care Record
❑ Discharge Instructions	❑ Hospice Records	❑ Pathology Reports	❑ Cardiovascular Reports
❑ Discharge Summary	❑ Lab Reports	❑ Physician Orders	❑ Mental Health Records
❑ EKG Reports	❑ Office/Progress Notes	❑ Drug/Alcohol Abuse Treatment	❑ HIV/AIDS Information

❑ Other_____

5. Purpose of Disclosure
❑ Continuation of Care ❑ Insurance ❑ Legal/Attorney ❑ Personal ❑ Other _____

6. **Expiration of Authorization**
Unless I request in writing otherwise, this authorization will expire on _____ (Insert expiration date or event). If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which it was signed.

7. **Right to Revoke Authorization**
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, must do so in writing and present the written revocation to the Health Information Management (HIM) Department of the Navicent Health System [Navicent Health, HIM Department, Attn: ROI, 777 Hemlock, MSC 148, Macon, GA; 312011.] I understand that the revocation will not apply to any health information that has already been released in response to this authorization. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization.

8. **Refusal to Authorize Use And/or Disclosure**
I understand that authorizing the use or disclosure of the information above is voluntary. I need not sign this form to ensure healthcare treatment. However, if I have been asked to sign this form in order to authorize the disclosure of my health Information for purposes related to research, or for other reasons, I understand that Navicent Health System may, decline to treat me if I refuse to sign this information only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information for such research, or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a pre-employment drug screen).

9. **Re-Disclosure**
I understand that if my health information is disclosed to a party other than a healthcare provider, health plan, or healthcare clearing house subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations. I understand this form does not authorize the disclosure of medical information beyond the limits of this authorization. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or state lay for mental health records, federal and state requirements prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such statutes or regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute criminally any alcohol or drug abuse patient.

10. **Release and Waiver**
If the health information that I have requested Navicent Health System to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infections disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), venereal disease, tuberculosis, or hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing It to the party or parties authorized above. I also release Navicent Health System, each of the Navicent Health System facilities checked above, and their officers, trustees, agents, and employees from any and all liabilities, damages, and claims which might arise from the release of the health information authorized by me above.

_____ _____
Printed Name of Patient or Personal Representative Date

_____ _____
Signature of Patient or Personal Representative Date

If signed by the individual's personal representative, state the legal authority of the representative to act on behalf of the individual: ☐ Parent ☐Court Appointed Guardian/ Healthcare Agent ☐Medical Power of Attorney

Document(s) of patient representative's authority must be attached if patient is not signing.

Acknowledgement of Medical Record Request Processing Fee

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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. The fee charged for all requests is detailed below:

	Produced/Requested Medium and Cost	
Format of Original Patient Record	**Cost for delivery in electronic format (CD/USB/download or portal**	**Cost for record delivery in paper**
Electronic or Hybrid (part electronic part paper)	• $6.50 flat fee for electronic portion • Plus, if applicable, $0.07 per page for CIOX Health's labor cost to create and deliver the portion of record maintained in paper • plus sales tax as applicable	• $0.07 per page for CIOX Health's labor cost to create and deliver the portion of record maintained in paper • Plus, if applicable, the lower of cost under state regulated patient rates or $0.90 for CIOX Health's average labor cost to create and deliver the portion of record maintained electronically • Plus $0.05 per page for supplies (paper and toner) • Plus actual postage if mailed • plus sales tax as applicable
Paper	• $0.07 per page for CIOX Health's labor cost to create and deliver the portion of record maintained in paper Plus actual postage if mailed • plus sales tax as applicable	• $0.07 per page for CIOX Health's labor cost to create and deliver the portion of record maintained in paper • Plus $0.05 per page for supplies (paper and toner) • Plus actual postage if mailed • plus sales tax as applicable

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.

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 CIOX Health.

Name:_____ Phone #:_____

Address:_____
Street City State Zip

Patient Signature: _____ Date:_____
(or authorized representative)

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