ROI

CoxHealth
Health Information Management

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

All sections of this authorization form MUST be completed to be valid in accordance with 42 CFR Parts 160 and 164

For ROI / HIM Use:
Account / Encounter#: _____
(or use Patient Label)

Patient Name: _____ Date of Birth: _____

Patient Address: _____ City: _____ State: _____ Zip Code: _____

Patient Email Address: _____ Phone: _____

I request my protected health information (PHI) be released FROM:

__ Cox Medical Centers – Springfield
__ Cox Monett Hospital
__ Cox Medical Center – Branson
__ Cox Barton County Hospital
__ Meyer Orthopedic & Rehab (MORH)
__ Emergency Department
__ Urgent Care
__ CoxHealth Monett Clinics – ALL
__ CoxHealth Branson Clinics – ALL
__ CoxHealth Springfield Clinics – ALL
__ CoxHealth Barton County Clinics – ALL
__ Ferrell-Duncan Clinics

__ Other: _____
(Specific Provider Location, Provider Name, and/or Document Type)

I request my protected health information (PHI) be released TO: *(Fax for healthcare provider only)*

Recipient Name: _____ Recipient Fax: _____

Recipient Address: _____ City: _____ State: _____ Zip Code: _____

Recipient Email Address: _____ Phone: _____

I authorize the following protected health information (PHI) to be released from my medical record(s):

__ Ambulance Trip Sheets
__ Emergency Room Record
__ Abstract/Pertinent Summary (dictated reports and test results)
__ Complete Medical Record (all pages)
__ Laboratory Reports
__ Pathology reports / slides
__ Radiology Reports
__ Radiology Film / Tracings / CD / Media
__ Itemized Billing
__ Complete Billing

__ Other: _____

I authorize the release of PHI that may include records relating to mental health care, communicable diseases, genetic information, HIV/AIDS and/or treatment of alcohol/drug abuse. I understand such records are protected under 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. 42 CFR Part 2 also prohibits such information from being redisclosed without the specific written consent of the patient or as otherwise allowed by law. A general authorization for the release of medical or other information is NOT sufficient for these purposes. These federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I choose not to have these records released. _____ (check here)

Period of health care covered:

__ Specific Date(s): _____ to _____ OR __ All past, present and future encounters / visits

Purpose for requesting information: __ Personal __ Legal __ Insurance __ Continuation of Care

How information is to be received (*if not marked, paper is default*):

__ US Mail - paper format __ Walk-in - paper format __ Electronic via secure E-mail format __ Fax (to healthcare provider only)

By signing this authorization form, I understand that:

- Requests for copies of medical records and/or non-document material may be subject to copying fees.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented in person to the Health Information Management Department at 1115 East Primrose Street, Suite 100, Springfield, Missouri 65807. Revocation will not apply to information that has already been released in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether or not I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

_____ _____
Patient / Authorized Representative Signature — Date

_____ _____
Printed Name of Authorized Representative — Relationship to patient

_____ _____
Witness Signature — Date

(Office Use only)
Identity of Requester Verified via:
__ Photo ID, Matching Signature
__ Other, Specify: _____
Verified by: _____

NOTE: If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

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INSTRUCTIONS

When picking up copies in person, a photo ID will be required as well as a copy of any legal papers (Power of Attorney, Executor of Estate, proof of custody, etc.) verifying legal right to request such information. This form may be used when requesting records to be SENT FROM a CoxHealth facility or from another health care provider to SEND TO a CoxHealth facility.

Mail completed form to: Medical Records, 1115 E. Primrose, Ste 100, Springfield, MO 65807

1. Complete the first section with current patient name, date of birth, phone number, and address.

2. Request Information from: Indicate the HOSPITAL or CLINIC (PHYSICIAN) you are requesting information FROM. If it is a CoxHealth hospital/clinic, the address is not necessary. Please specify which Cox facility you are requesting information from (i.e.: Springfield, Monett, Branson, etc.)

3. Release to: If the copies are for personal reasons and you are picking them up - state "Self". If "Self" and the address are the same as the top section, this can be left blank and indicate "same". If the records are being picked up by another person or mailed, please provide the complete name and address of the person/agency/etc. you would like us to give/send the copies to.

4. Type of PHI (protected health information) or medical records to be released. Most healthcare providers wish to have an "abstract" of the record, this includes all diagnostic test results and all physician dictation. Mark all documents you would like to receive.

   Radiology or Other Film/CD: X-ray films are NOT kept in the HIM (Medical Records) department. If this is all that is being requested, please send the authorization form to the appropriate department (Radiology, Cardiovascular Services - Heart Institute, etc.) at the appropriate facility.

5. Covering the period of healthcare from: This is used to specify the date range in which treatment was received. If you do not know the exact dates the approximate month and correct year will be accepted. Example May 2002 through March 2003. If you wish to release a series of visits extending into the future, you can enter the option of "past, present, and future."

6. Reason for Requesting Info: Please indicate why you want this information copied or sent, (i.e.: personal copy, continuation of care by a physician, insurance claim, legal issues, etc.)

7. How information is to be received. Unless indicated differently, records will be mailed to the address provided. Electronic records can be sent in a PDF format to a valid email address via Ciox's eDelivery website. You will receive an email from Ciox.com containing instructions for accessing your records. If there are fees for collecting your records and invoice will be included with the records. If walk-in is selected and paper prints are large in quantity, a call for pick-up will be arranged.

8. Patient Signature: Patient should sign and date the form.

9. Authorized Representative: If the request is being made by an authorized representative of the patient (parent of a minor, person named on Power of Attorney, executor of estate, etc.), the representative will sign and date the form and provide printed name and relationship to the patient. Proof of representation will be required before releasing information.

10. Expiration Date: If no date is provided, the authorization will only be valid for one (1) year from the date of signature/request as per CoxHealth policy.

Please contact the Medical Records Department, Release of Information for questions or concerns.

Springfield & Monett at 417-269-6138. Branson at 417-348-8600. Barton County at 417-681-5152.