204-IN (2020) Authorization for Release of Medical & Billing Records

Find us on the web at: ***https://www.ahni.com***

Site ID: _______

Please note that there may be a charge for providing copies of your medical records as allowed by Federal & State Law

Medical Records of (Patient Information):

First:____ Date of Birth:_____________

Maiden/Middle:__________________________________

Last:____ Last 4 digits of SS #:_________

Address: Street Name:____

City:_________________________________ State_______ Zip Code_________

Telephone:____________________________ Email:___________________________

Return Completed Form to Your AHN Doctor's Office At:

American Health Network of Indiana, LLC

Practice Name:__________________________

Address:_______________________________

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_______________________________________ OR

Fax To: _______________________________

Telephone:_____________________________

RECORDS TO BE RELEASED FROM: American Health Network of Indiana, LLC ("AHN"):

Practice or physician name & address: ____

RECORDS TO BE RELEASED TO: I, _____________________ request and authorize AHN to release my medical & billings records as indicated below to:

Name of person or organization receiving records: ____

Address: ____

Fax:__________________________ Telephone:_________________________ Email:_______________________________________

FORMAT & METHOD OF DELIVERY*: AHN will provide paper copies of the requested records. You may request an alternative delivery format, and if we are able, we will provide the records in the requested format:* ____

REASON FOR DISCLOSURE (*For the purpose of):*

Continuing Care	Referral to a Specialist	Change of Doctor/Provider	Personal
Insurance	Workers Comp	Disability Determination	Legal

INFORMATION TO BE RELEASED: At my request, I authorize disclosure of my health information as indicated below (*check all that those that apply*):

Date(s) of service: From_______________ to __________ OR, Last two years

AHN provider notes	AHN X-ray reports
AHN Special Diagnostic test results	AHN Chemical/Alcohol Treatment records
AHN Lab reports	ALL AHN Medical & Billing Records:
AHN Billing records	Other (specify)

SPECIAL LIMITATIONS: **Unless I HAVE LIMITED BELOW**, I understand that the release of records also pertains to those records regarding testing and treatment **for alcohol/substance abuse**, **human immunodeficiency virus (HIV) and/or AIDS**, and for **psychiatric treatment or counseling or communicable disease.** Or, Indicate **LIMITATIONS BELOW:**

1. Confine to **summary information** from records regarding treatment for following condition or injury: ____On or about (date(s) ___________________
2. Other: ____

*****Note: AHN has contracted with a third party copy service vendor (CIOX Health) to process requests for, and produce medical records. There may be a charge for providing a copy of your records as allowed by Federal and State Law. Carefully review attached fee schedule .***

I UNDERSTAND: (1) THAT THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE IN SIXTY (60) CALENDAR DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE; (2) I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY CALLING AHN PRIVACY OFFICE AT (317) 580-6369 OR BY EMAIL AT: AHN_privacy@ahni.com; HOWEVER, THE REVOCATION WILL NOT HAVE AN EFFECT ON ANY ACTIONS TAKEN PRIOR TO THE DATE MY REVOCATION IS RECEIVED AND PROCESSED BY AHN. (3) MY HEALTH INFORMATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE AUTHORIZED RECIPIENT, AND IF THE RECIPIENT IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE INFORMATION MAY NO LONGER BE PROTECTED BY THE FEDERAL PRIVACY REGULATIONS, AND THAT AHN WOULD NOT BE RESPONSIBLE FOR THIS ACTION; (4) I AM ENTITLED TO ASK FOR AND RECEIVE A COPY OF THIS DOCUMENT, AND; (5) I AM NOT REQUIRED TO SIGN THIS AUTHORIZATION IN ORDER TO RECEIVE HEALTH CARE TREATMENT AND AHN WILL NOT CONDITION TREATMENT, PAYMENT, ON WHETHER I SIGN THIS AUTHORIZATION. ***Specify authorization expiration date (if not 60 days)*** __________

Patient Signature: ____Date______________________________

Patient Legal Representative: ______________________ ____________________ __________________ __________

(Name) *(Relationship to patient)* *(Signature)* *Date)*

For Office Use

Date Received: ________________________ **Received by:** _______________________

Date Released: ________________________ Released by: _______________________ File: See instructions in policy # 203

CIOX HEALTH

Effective Date: 8/23/2016

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. The fee charged 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 delivered 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.

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 CIOX Health 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 CIOX Health.
Patients may also pay for their invoices online at **www.healthportpay.com**.