American Health Network
Part of Optum

Site ID: _____

AHN IN: AUTHORIZATION TO RELEASE MEDICAL & BILLING RECORDS

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

AHN_PatientForm.004a.2022
Individual Rights: Request for records

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

PATIENT INFORAMTION (whose information is being requested):

First:_____ Date of Birth: _____

Maiden/Middle:_____ Last 4 digits of SS #_____

Last:_____ Today's Date: _____

Address: Street Name:_____

City:_____ State_____ Zip Code:_____

Telephone: Email:_____

Return Completed Form To:

American Health Network of Indiana, LLC

Practice Name:_____

Address:_____

_____

_____

OR Fax To: _____

Telephone:_____

RELEASE MY RECORDS FROM American Health Network of Indiana Part of Optum (*AHN will only release records from the practice/provider you list below*)

Practice or physician name & address: _____

RELEASE MY RECORDS TO: I request and authorize AHN to release my medical & billings records as indicated below to:

_____

Address:_____
Street Name) (City) (State) (Zip code)

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 (Requested alternative delivery format): _____*

FOR THE PURPOSE OF (*reason for disclosure):*

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

INFORMATION TO BE RELEASED At my request, I authorize the release of my protected health information as indicated below (*check all 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 Lab reports	☐ AHN Chemical/Alcohol Treatment records	☐ AHN Billing records
☐ ALL Medical Records	☐ Other (specify)_____	

SPECIAL AUTHORIZATION: **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.** By putting a check mark below and signing this form, I authorize AHN to release records about me pertaining to: **(Indicate BELOW):**

☐ **Alcohol, Drug, or Substance Abuse**	☐ **Communicable disease.**
☐ **Human immunodeficiency virus (HIV) and/or AIDS,**	☐ **Genetic**
☐ **Psychiatric treatment or counseling**	☐ **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 the attached copying fee schedule. Contact your AHN provider for question.

I UNDERSTAND: (1) THIS AUTHORIZATION WILL EXPIRE IN SIXTY (60) CALENDAR DAYS FROM THE DATE SIGN ED, UNLESS I SPECIFY OTHERWISE. IF AUTHORIZATION WILL NOT EXPIRE IN SIXTY (60) DAYS, SPECIFY AUTHORIZATION EXPIRATION (Not to exceed 180 days) DATE_____ (2) I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY PRESENTING A WRITTEN REVOCATION NOTICE TO MY AHN PRIMARY CARE PROVIDER OR BY MAILING TO: PRIVACY 7440 Woodland Drive, Indianapolis, IN 46278; 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.

Patient Signature: _____ Date_____

Legal Representative: _____
(Must provide legal documentation) (Name) (Relationship to patient) (Signature) (Date)

For Office Use: Date Received_____; Received by _____

Date Released:_____Released by:_____

Updated: 01/05/2018; 03/17/2020; 04/28/2021; 03/15/2022

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 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 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. 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 https://www.paycioxhealth.com/pay/.

Thank you,

CIOX Health

Secure Online Medical Records Request

An easier, faster way to ask for your records

Use our secure online form to ask for a copy of your records.

Go to: swellbox.com/american-health-network-wizard.html

Or scan the QR code →

Optum

American Health Network
Part of Optum®

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us such as letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call 888.255.2246., TTY 711. ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 888.255.2246., TTY 711. 請注意：如果您說中文 (Chinese), 我們免費為您提供語言協助服務。請 致電：888.255.2246., TTY 711.