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

PATIENT INFORMATION: (*whose information is being requested*)

First:____ Date of Birth:____________

Maiden/Middle:_______________________________ Last 4 digits of SS #:______

Last:____

Address: Street Name:____

City__________________________________ State_______ Zip Code_______

Telephone:____________________________ Email:________________________

RETURN COMPLETED FORM TO:

American Health Network of Ohio, LLC

Practice Name:____________________

Address:______________________________
____
____

OR Fax To: _______________________

Telephone:________________________

RELEASE MY RECORDS FROM: American Health Network of Ohio Part of Optum (*AHN will only release records from the practice/provider you list here*): Practice or physician name & address: ____

RELEASE MY RECORDS TO: I request and authorize American Health Network of Ohio, LLC ("AHN") to release my medical & billing records as indicated below to (*Name of person or organization receiving records*):
____

Address: ____ ___
(*Street Name*) (*City*) (*State*) (*Zip code*)

Fax: ________________________Telephone: ________________________ Email: ____

METHOD OF DELIVERY: *AHN will provide paper copies of the requested record. 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
All Medical records	Other (Specify)		

INFORMATION TO BE RELEASED: At my request, release the following information (*check all that apply*):

Date(s) of service: From_______________ to __________ OR, Only last two years year

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

SPECIAL AUTHORIZATION: Unless I HAVE LIMITED BELOW, I understand that the release of records also pertains to those 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's office if you have questions

I UNDERSTAND: (1) THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED OR SHALL EXPIRE ON DATE OR EVENT SPECIFIED BELOW. (2) THAT I HAVE THE RIGHT TO REVOKE OR CANCEL THIS AUTHORIZATION AT ANY TIME BY PRESENTING A WRITTEN REVOCATION NOTICE TO MY AHN PRIMARY CARE PROVIDER OR BY MAILING TO: PRIVACY 2500 CORPORATE EXCHANGE STE. 100 COLUMBUS, OH 43229, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN BASED UPON IT, AS DESCRIBED IN THE AHN PRIVACY NOTICE. IF THIS AUTHORIZATION HAS NOT BEEN REVOKED, IT WILL EXPIRE ON THE DATE OR COMPLETION OF THE EVENT STATED BELOW. IF NO DATE OR EVENT IS SPECIFIED BELOW, THIS AUTHORIZATION WILL EXPIRE IN ONE YEAR. (3) THAT THE RECIPIENT OF THESE RECORDS MAY FURTHER DISCLOSE INFORMATION BECAUSE OF THIS AUTHORIZATION AND THEN IT 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) THAT I MAY NOT BE DENIED TREATMENT, PAYMENT, AND ENROLLMENT IN THE HEALTH PLAN, OR ELIGIBILITY FOR BENEFITS FOR REFUSING TO AUTHORIZE DISCLOSURE UNLESS SUCH DENIAL IS PERMITTED UNDER STATE AND FEDERAL LAW. Specify Expiration Date or Event: ______________________________

Patient Signature:_____________________________________ Date___________________________________

Patient Legal Representative: ___________________________ ________________________ ____________________ __________
(Must present legal prove of legal representation) (Name) (Relationship to patient) (Signature) (Date)

For Office Use only:

Date Received: ____________________________ **Received by:** ___________________________

Date Released: _________________________ Released by: ________________________

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**.