

*Note:

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

AHN IN: AUTHORIZATION TO RELEASE MEDICAL & BILLING RECORDS

Site ID:

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

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

Date of Birth: Date / Address: Practice Name: Address: Street Name: State Zip Code: OR Fax To: Telephone: Email: Telephone: RELEASE MY RECORDS FROM American Health Network of Indiana Part of Optum (AHW will only release cereds from the practice/provider you list below) Practice or physician name & address: Telephone: RELEASE MY RECORDS FROM American Health Network of Indiana Part of Optum (AHW will only release cereds from the practice/provider you list below) Practice or physician name & address: Practice or physician n	IENT INFORAMTION (whose				nes of your medici		oleted Form To:	
ENTAINED TO SET TO THE PURPOSE OF (reason for disclosure): Continuing Care Workers Comp Disability Determination Legal Other								
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Fax: Telephone: Email FORMAT & METHOD OF DELIVERY: A reliephone 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 Olds and the provider of the purpose of referral to a Specialist Change of Doctor/Provider Personal Olds and the provider of the purpose of the requested health information as indicated below (check all those that Olds and the purpose of the release of my protected health information as indicated below (check all those that Olds and the provider notes OR, OR, Alman Special Diagnostic test results Special Diagnostic test results and treatment for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AlDS, 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. Belia	Practice or physician name	& address: _						
Fax: Telephone: Email FORMAT & METHOD OF DELIVERY: A reliephone 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 Olds and the provider of the purpose of referral to a Specialist Change of Doctor/Provider Personal Olds and the provider of the purpose of the requested health information as indicated below (check all those that Olds and the purpose of the release of my protected health information as indicated below (check all those that Olds and the provider notes OR, OR, Alman Special Diagnostic test results Special Diagnostic test results and treatment for alcohol/substance abuse, human immunodeficiency virus (HIV) and/or AlDS, 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. Belia	Address:		Chant Name			(Cit.)		
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 Other Insurance Workers Comp Disability Determination Legal Other NFORMATION TO BE RELEASED At my request, I authorize the release of my protected health information as indicated below (check all those that 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: ILINDERSTAND: (1) THIS AUTHORIZATION WILL EXPIRE IN SIXTY (60) CALENDAR DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE, IF AUTHORIZATION WILL EXPIRE IN SIXTY (60) CALENDAR DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE, IF AUTHORIZATION WILL NOT EXPIRE IN SIXTY (60) CALENDAR DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE, IF AUTHORIZATION WILL NOT EXPIRE IN SIXTY (60) CALENDAR DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE, IF AUTHORIZATION WILL NOT EXPIRE IN SIXTY (60) CALENDAR DAYS FROM THE DATE SIGNED, UNLESS I SPECIFY OTHERWISE, IF AUTHORIZATION WILL								
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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







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.

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