



CoxHealth

For ROI / HIM Use Only:

Authorization for Use and Disclosure of Protected Health Information

Account / Encounter#: _____
(or Patient Sticker Here)

Please **PRINT** in blue or black ink.

All sections of this authorization form MUST be completed to be valid.

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

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

☐ 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 allows other part 2 programs, covered entities and business associates to redisclose this information without written consent of the patient if permitted by HIPAA. These federal regulations restrict any use of the information for civil, criminal, administrative, or legislative proceedings against 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 (ie: 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, (ie: 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 MRO's eDelivery website. You will receive an email from MRO.com containing instructions for accessing your records. If there are fees for collecting your records an 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