AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Name of Patient:_____ **Social Security # (Last 4 digits only) :**_____
Phone Number:_____ **Date of Birth:**_____
Email:_____

1. I, or my authorized representative, request Mount Sinai South Nassau and its Affiliates to provide the following information:

☐ Abstract/Summary of Medical Record (includes: H&P, Discharge Summary, Diagnostic Results, Medication Ordered/given, operative reports)	
☐ Emergency Room Record	☐ History and Physical
☐ Discharge Summary	☐ Operative Reports
☐ Consultation Report(s)	☐ Discharge Plan and/or Instructions**
☐ Entire Medical Record	☐ Radiology Films & CD's
☐ Diagnostic Testing: Radiology	☐ Pathology/Lab Slides
☐ Diagnostic Testing: Lab	☐ Other (Specify):
☐ Diagnostic Testing: Pathology	

2. Date Range of PHI to be released: _____

Reason for Release:	☐Personal Copy	☐Continued Care	☐Insurance	☐**Designated direct care giver

*** Information to be released only includes all medical information contained in the discharge plan &discharge instructions.*

3. Person(s) to whom this information will be sent by Mount Sinai South Nassau and its Affiliates:

Myself (patient or patient representative)	**Other/Doctor**	****Designated Care Giver:**
Name:	Name:	Name:
Address:	Address:	Address:
City/State/Zip:	City/State/Zip:	City/State/Zip:
Phone #:	Phone #:	Phone #:

This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEATLH TREATMENT, except psychotherapy notes, CONFIDENTIAL HIV RELATED INFORMATION, and GENETIC TESTING INFORMATION only if I place my initials on the appropriate line below. I specifically authorize release of such information to the person(s) indicated in item 3 above.

Include: (indicate by initialing)			
_____Alcohol/Drug Treatment	_____ Mental Health Information	____HIV-Related Information	____ Genetic Testing Information

I understand the following:

- The signing of this authorization is voluntary. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
- This authorization may be revoked by written notification from the undersigned to the Health Information Management Department or applicable offsite location, except to the extent that action has already been taken based on this authorization.
- Information disclosed under this authorization might be redisclosed by the recipient and this redisclosure may no longer be protected by federal or state law.

Date or event on which this authorization will expire: _____

If not the patient, name of person signing form:	**Authority to sign on behalf of patient:**

I certify that I have read, signed and received a copy of this authorization upon my request.

_____ **Signature of patient (or representative authorized by law.)**	**Date:** _____

Please allow up to 7 business days for the processing of your request. Your record is being processed by: CIOX HEALTH

Internal Use: MR#_____ **ROI#**_____ **Number of Page Released**_____
Date Released:_____

Mount Sinai South Nassau -One Healthy Way Oceanside, NY 11572
Tele: (516) 632-3907 **Fax:** (516) 470-6031 Email:
MedicalRecordRequests@snch.org

Information about Your Medical Record Request

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 (electronic/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.