THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

HIM Client Services
Release of Information
T: 713-792-6710
Unit 1632
7007 Bertner Ave
Houston, TX 77030-4004

Attention MD Anderson Patients:

This email/fax contains 2 forms that you will need to complete in order to obtain your medical records. For your convenience we will accept the completed forms via email to rol@mdanderson.org, via fax to 832-750-3013 or mailed to 7007 Bertner Ave. Unit 1632 Houston, TX 77030.

Instruction for completing attached forms:

- If you are requesting that your records to be sent to a physician's office or hospital for continuing care, please only complete the Authorization for Disclosure of Health Information form. Once the completed form is received, a ROI Specialist will fax your records to the physician's office or hospital within 24 business hours (3 business days).

- If you are requesting your medical records for personal use and would like for records to be sent directly to you via *US Postal Service*, please complete Authorization for Disclosure of Health Information and the Healthport Fee Schedule. Once the completed forms are received, a ROI Specialist will complete your request within 7 to 10 business days, also if requesting records to be send to a third party organization this to apply. ***Please note that we cannot fax your records back to you, they must be mailed per HIPPA Privacy Rule.***

- If you are requesting your medical records for personal use and would like for records to be electronically delivered to you via email, please complete all 2 attached forms. Once the completed forms are received, an ROI Specialist will complete your request within 7 to 10 business days.

- All required forms must be signed. We are unable to accept electronic signatures. We apologize for any inconvenience.

If you have any questions, please contact the Release of Information Dept. @ 713-792-6710 and a ROI Specialist will be glad to assist you.

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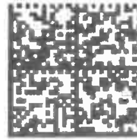
Authorization for the Use and Disclosure of Protected Health Information (ROI)



PATIENT:
MDA MRN:
LOCATION:
PRINT DATE: 7/23/2018;
DOB:
SEX: FC:

Patient Name: ______ DOB: ______ MRN: ______
Patient Phone: ______ Email: ______

I authorize **MD Anderson Cancer Center** to disclose the following Protected Health Information from the medical record (including Proton Therapy Center records) of the patient named above to:

Name (person or organization): ______
Address: ______
Phone: ______ Fax: ______ Email: ______

By: ☐ Fax ☐ Email ☐ Mail ☐ Hold *(patient pick up)* ☐ myMDAnderson **Format** ☐ Paper/Hard Copy ☐ Electronic

Information to be disclosed *(check all that apply)* for date range ______:

Health Information Management
- ☐ Entire Legal Medical Record
- ☐ ***Abstract of Record**** ***(includes items in bold/italics)***
- ☐ Cardiology Notes / Reports
- ☐ Chemotherapy Notes
- ☐ ***Consultation Notes***
- ☐ ***Diagnostic Imaging Notes/Reports***
- ☐ ***Discharge Summary***
- ☐ ***History/Physical (H&P)***
- ☐ Laboratory Tests
- ☐ Nurses Notes
- ☐ **Operative Reports**
- ☐ **Pathology Reports**
- ☐ ***Primary Medical Evaluation***
- ☐ Progress Notes
- ☐ Radiation Oncology Notes

Pathology
- ☐ All Pathology Records
- ☐ Slides
- ☐ Blocks
- ☐ Reports
- ☐ Other: ______

Other
- ☐ Billing Records *(available in paper format only)*
- ☐ Psychotherapy Notes
- ☐ Research Records
- ☐ Photographs/Videos
- ☐ FMLA, Disability, Return-to-work and/or Worker's Compensation forms and associated records/notes
- ☐ Other: ______

Diagnostic Imaging
Please specify item (e.g., recent X-ray):
______
______
______
______

Radiation Oncology
- ☐ Treatment Plan(s)
- ☐ Simulation Images
- ☐ Port Images
- ☐ Other: ______

Outpatient Pharmacy
- ☐ Prescription Records

I understand that sensitive information (such as, HIV/AIDS Treatment Records and Mental Health Records) may **be disclosed unless prohibited here:**

DO <u>NOT</u> DISCLOSE: ☐ Mental Health Records ☐ Genetic Information *(including test results)*
☐ HIV/AIDS Treatment Records ☐ Sexually-Transmitted Diseases ☐ Substance Abuse Treatment Records
☐ Other: ______.

Note: ***It may not be possible to remove this information from billing or medical records when embedded in the text of some provider's notes. Release of Psychotherapy Notes (as defined by HIPAA) requires a separate written Authorization.***

I authorize disclosure of the information noted above for the following purpose(s):

☐ Personal Use ☐ Continuation of Care ☐ Work-related (FMLA, workplace accommodations) ☐ Legal/Litigation
☐ Payment/Insurance ☐ Worker's Compensation ☐ Research ☐ Disability Insurance
☐ Education (e.g., external presentations, publications) ☐ Other: ______

I understand this authorization will expire one (1) year from the date the authorization is signed, or upon the following date or event (specify): ______.

I understand that once disclosed, my information may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I may revoke this authorization in writing at any time, except when MD Anderson has already relied on this authorization or the information is no longer under MD Anderson's control. I can revoke this authorization by sending a written request to Privacy Officer, MD Anderson Cancer Center, Institutional Compliance Office, Unit 1640, PO Box 301407, Houston, TX 77230-1407, Phone: 713-745-6636, Fax: 713-563-4324 or at PrivacyCompliance@mdanderson.org.

This authorization is optional and I do not have to sign it. Refusing to sign will not affect my treatment or payment for services.

Signature of Patient or Legally Authorized Representative: ______
Printed Name of Signor: ______ Date/Time: ______
Legally Authorized Representative's <u>Relationship to Patient</u> *(check all that apply)*:
☐ Parent ☐ Guardian ☐ Other** *(specify)*: ______

Hospitals and providers may fax requests to 832-750-3013 & 1-855-884-3253. Patients may send requests by email: roi@mdanderson.org or U.S. Mail: 7007 Bertner Avenue, Unit 1632, Houston, TX 77030.

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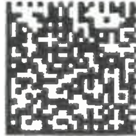
Release of Information Fee Schedule



PATIENT:
MDA MRN:
LOCATION:
PRINT DATE: 7/23/2018;
DOB:
SEX: FC:

Patients requesting a copy of their medical records for continuation of care may have their records sent directly to another healthcare provider at no charge. If a patient is requesting to hand carry the records or retain a copy for his or herself, a fee is charged in accordance with state and federal law. MD Anderson Cancer Center's Release of Information services is handled by CIOX Health. CIOX accepts payments mailed to the address provided on the invoice or they accept payments over the phone by calling 1-800-367-1500. You may also pay online at www.healthportpay.com.

The Medical Record Copy fees are based on the form and format of the original health record. Your record at MD Anderson may be stored in an electronic health record or in paper format and some are both paper and electronic which is called a hybrid record.
The Ciox copy fees below are for Patients Only.

Fees for an electronic copy of your record	Fees for a paper copy of your record
If your original record is electronic and delivered via My Chart there is NO CHARGE. **When your original record is electronic and provided on CD:** • $6.50 flat fee for the electronic medical record copies • Plus sales tax as applicable **When your original record is in paper and you are requesting an electronic copy:** • $0.07 per page for the labor to convert the paper record to electronic format • Plus sales tax as applicable **When your record is Hybrid and you are requesting a CD or delivery via Ciox eDelivery portal:** • $6.50 flat fee for the electronic medical record copies • $0.07 per page for the paper record delivered to you electronically • Plus sales tax as applicable	**Records requested and picked up on site that are 20 pages or less are NO CHARGE.** **Records released to My Chart are NO CHARGE.** **If your original record is electronic:** • $0.90 base fee for labor to convert the electronic record to paper • $0.05 per page for supplies (paper and toner) • Plus Sales tax as applicable and actual postage and handling **If your record is maintained in paper and you are requesting a paper copy:** • $0.07 per page for labor to produce the paper copy • $0.05 per page for supplies (paper and toner) • Plus sales tax as applicable and actual postage and handling **If your record is Hybrid and you are requesting it to be delivered in paper:** • $0.90 base fee for labor to convert the electronic record to paper • $0.07 per page for labor to produce the paper copy • $0.05 per page for supplies (paper and toner) • Plus Sales tax as applicable and actual postage and handling

****LEGALLY AUTHORIZED REPRESENTATIVES & PROOF OF IDENTIFY**

The following individuals may authorize the release of records on behalf of a living adult patient:
- Agent appointed under a Medical Power of Attorney/Durable Power of Attorney for Health Care (when patient has been certified incompetent)
- Legal guardian (if patient has been certified incompetent) Attorney Ad Litem or Guardian Ad Litem
- Attorney retained by the patient or the patient's Legally Authorized Representative

The following individuals may authorize the release of records on behalf of a deceased adult patient:
- Executor, Administrator, or other court-appointed Personal Representative of the deceased patient's estate. If there is no Executor, Administrator, or court-appointed Personal Representative, then the following individuals, in this order:
  - Decedent's spouse
  - Adult children of the decedent
  - Adult grandchildren of the decedent
  - Parents of the decedent
  - Adult brothers and sisters of the decedent
  - Adult children of the brothers and sisters of the decedent
  - Adult grandchildren of the decedent's brothers or sisters
  - Grandparents of the decedent
  - Adult uncles or aunts of the decedent

The following may authorize the release of records for patients who are minors:
- Parent or legal guardian
- Person acting in loco parentis with legal authority to make decisions on behalf of the child
- When a custody decree exists, the parent(s) who can make health care decisions for the child

When requesting records, you may be asked to provide one or more of the following documents:
- Photo identification
- Proof that you are the Executor/Administrator/Representative of a deceased patient's estate
- Medical Power of Attorney accompanied by a Physician Statement
- Death Certificate and/or Birth Certificate
- Proof of Legal Guardianship/Custody

I have read and understand the above.

Name:______________________________ Date:______________________________