CYPRESS POINTE HOSPITAL

HIPAA Compliant Authorization for the Release of Patient Information Pursuant to 45 CFR 164.508

42570 S. Airport Road
Hammond, LA 70403
Phone: (985) 510-6140
Fax: (985) 543-0918

☐ **ID VERIFIED**

Patient Name: _____ Medical Record Number: _____

Date of Birth: _____ Home Phone: _____ Cell Phone: _____

Address: _____

Is this address where you want the medical records sent? ☐ Yes ☐ No (If No, please list alternative address)

Alternate Address: _____

Would you like to receive these records electronically? ☐ Yes ☐ No

Uses and disclosures of your Protected Health Information, including uses and disclosures of psychotherapy notes, will be made only with your written authorization, unless otherwise permitted or required by law.

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

Cypress Pointe Surgical Hospital
Attention: Medical Records
42570 S. Airport Road ● Hammond, LA 70403
Phone: (985) 510-6140 ● Fax: (985) 543-0918

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ Physician Orders and Progress Notes ☐ Entire Record
☐ Medication List ☐ Most Recent History and Physical
☐ Operative Report ☐ Most Recent Discharge Summary
☐ Laboratory Results from (date) _____ to (date) _____
☐ Discharge Instructions from (date) _____ to (date) _____
☐ Consulting Reports from (doctor's name) _____
☐ Other: _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health or mental health services, or treatment for alcohol and drug abuse. 42 CFR 2.31

5. This authorization shall expire on the following date or event: _____**.** If I fail to specify an expiration date or event, **this authorization will expire (12) months from the date on which it was signed**.

6. This information may be disclosed to and used by the following individual or organization: *(If you would like to give a family member or another individual / organization access to your medical records please list their name and address below.)*

_____

_____

Purpose of disclosure: ☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other _____

7. I understand the following: see CFR §164.508(c)(2)(i-iii)

a.) I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b.) The information released in response to this authorization may be re-disclosed to other parties.

c.) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information that carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer at **(985) 510-6157**.

_____ _____
Signature of Patient or Legally Authorized Representative Date Signature of Witness

_____ _____
Name and Relationship of Legally Authorized Representative to Patient Date Date of Witness

☐ Received on ____/____/_____ _____
Signature of Recipient

Please allow 10 business days for the completion of processing your request.
Upon completion you will receive an invoice from CIOX Health, Our contracted release of information provider.
See reverse for pricing details.
If your medical records are being sent directly to a physician there will be no charge.

 In Accordance with Louisiana Revised Statutes 40:1299.96. This information can be found at http:www.legis.state.la.us/lss/lss.asp?doc=972591

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 captures your protected health information from the Cypress Pointe Surgical Hospital 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 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 (866)420-7455 if you have any questions about the services CIOX Health provides on Cypress Pointe Surgical Hospital'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 invoice's online at www.healthportpay.com