Authorization for Release of Medical Record Information
(Not to Be Used for a Patient Access Request)

I hereby authorize Lee Health to release my protected health information including information from my medical record which may include HIV (AIDS) testing, sexually transmitted disease, mental health and/or substance abuse services. I further release Lee Health from all legal responsibility and/or liability that may arise from the release of such records as specified above and I hereby waive all rights I have to preserve such records confidentiality. You may **fax to (239) 343-4189 (Release of Information) or hand deliver to a Lee Health facility.**

Patient's Legal Name:______________________________ Date of Birth: ______________

Telephone: (__________) ______________________________

Address:______________________________ City: ____________ State: ________ Zip: __________

The information is to be: ❑ Mailed to ______________________; ❑ Picked-up Date: ______________________

❑ Electronic Delivery (additional form to be completed)

The request is subject to the limitations as listed below and is for the purpose of:

❑ Personal ❑ Payment ❑ Healthcare Operations ❑ Other: ______________________

❑ Treatment (Continued Care) ❑ Physician Appointment(Date/Time): ______________________

Please furnish the following:

❑ Emergency Dept. Notes ❑ Consultation ❑ Physician Office Notes ❑ Immunizations

❑ Discharge Summary ❑ Physician Orders ❑ Operative Record ❑ HIV Results (AIDS Testing)

❑ History & Physical Exam ❑ Progress Notes ❑ Pathology Report ❑ Laboratory Results

❑ Radiology Tests ❑ Diagnostic Tests ❑ Psychiatric/Psychological Testing (Mental Health)

❑ Other: ______________________________

This authorization is for the listed date(s) of treatment:

From (Date):______________ To (Date):______________ Special Instructions: ______________________

I further agree to pay fees charged to provide the information requested.
I understand that fees are within the fee allowed by Florida Law.

Pursuant to Florida Statute 395.3025

The exclusive charge for copies of patient records may include sales tax and actual postage, and except for nonpaper records, that are subject to a charge not to exceed $2, may not exceed $1 per page. A fee of up to $1 may be charged for each year of records requested. These charges shall apply to all records furnished, whether directly from the facility or from a copy service providing these services on behalf of the facility. However, a patient whose records are copied or searched for the purpose of continuing to receive medical care is not required to pay a charge for copying or for the search.

Patient Initials:____________

Consent to Minors

Minors are permitted to consent to medical care and treatment in the following situations. Thus, the parents are not entitled to the minor's information without written consent of the minor, a valid subpoena or court order.

1. A minor who is, or has been, married.
2. An unwed pregnant minor consenting to the performance of medical or surgical care or services relating to her pregnancy.
3. An unwed minor mother consenting to the medical or surgical care or services of her child.
4. A minor seeking voluntary substance abuse impairment services.
5. A minor consenting to the examination and treatment of a sexually transmitted disease.
6. A minor receiving contraceptive information or services.
7. A minor with a court order removing the disability of nonage.
8. Unless a parent objects in writing, any minor who has reached the age of 17 years may give consent to the donation, without compensation therefore, of his blood and to the penetration of tissue which is necessary to accomplish such donation.

The fees are waived only if the copies are forwarded directly to a physician office and/or health care provider.

I understand that this authorization is voluntary and that I may refuse to sign it. Lee Health will not condition treatment, payment, enrollment in a health plan, or eligibility for benefits on the individual providing authorization of the requested use as stated above. This authorization may be revoked except to the extent that action(s) have been taken as outlined by this authorization. The revocation must be in writing to the Lee Health Privacy Officer by mail to Privacy Officer P.O. Box 2218, Fort Myers, FL 33902 or e-mail at PrivacyOfficer@LeeHealth.Org. I understand that I have the right to inspect or copy the protected health information to be used or disclosed pursuant to this authorization. Information used/disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Privacy Rules.

Patient Signature:______________________________Date/Time: ______________

If the legal representative, sign below and state relationship and authority to do so and attach a copy of the document of authority.

Legal Representative:______________________________Authority: ______________

Custodial Parent/Guardian:______________________________Date/Time: ______________

This authorization is in effect until______________________________or for 1 year from the date signed.

You have requested an electronic copy of your medical records. CIOX Health will, under agreement with this healthcare provider, facilitate the release of your records based on your authorization.

You will receive an email from CIOX Health, at the email address you have provided, that will include detailed instructions on how to access your electronic records via a secure web portal. Once you have received the email notification from CIOX Health, the medical record will be available via the web portal for 90 days. If the record is not accessed during that timeframe, it will be deleted from the portal. If you need the record after that time, you must resubmit your authorization to the healthcare facility.

To access the record electronically your computer must meet or exceed these requirements:

- Windows or Mac platform
- Pentium 3 or mac G3 or higher
- At least 128 MB of RAM
- Internet Explorer 6.0 or 7.0 with 128-bit encryption pack or Netscape 4.77
- At least 56K modem; however, DSL or T1 line is recommended
- Adobe Reader (latest version available free from www.adobe.com)
- 200 dpi (or higher) printer (for printing records)

Payment regulations vary from state to state, therefore, depending on the location of the medical facility that you requested records from, there may be a charge associated with this service. If that is the case, you may receive an invoice from CIOX Health along with the medical record.

If you have any questions or to check on the status of the medical record, please call us directly at (800) 367-1500, #4.

Kind Regards,
CIOX Health

Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than printed copies.

Requester Name		
	FIRST	LAST
Street Address		
	STREET	SUITE / APT #

	CITY	STATE	ZIP

EMAIL ADDRESS FOR RECORD DELIVERY

MEDICAL RECORDS REQUESTED			
Patient Name			
	FIRST	MI	LAST
Date of Birth			
Date of Service			
	FROM	TO	

Please provide me with the medical records described above through the CIOX Health eDelivery online service.

I understand and agree that:

- I must provide a valid email address, either of my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on CIOX Health's **eDelivery** website.
- I will receive an email from **CIOXHealth.com** containing instructions for accessing my records.
- There may be a fee for collecting my records. If so, an invoice will be included with the records.
- If I request that my medical records be sent to an unsecured e-mail address rather than through the CIOX Health eDelivery online service, I am accepting the risk of using unsecured e-mail. A non-exclusive list of risks associated with using unsecured e-mail for delivery of medical records is listed below.

Signature:____Date:/Time: _____________________

RISKS OF USING UNSECURED E-MAIL FOR MEDICAL RECORDS DELIVERY

Email is inherently unsecure unless it is fully encrypted requiring the use of strong authentication and password protection. Most email does not meet those standards. As a result, when we send your medical records by unsecured e-mail, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it. Below are some, but not all, of the many risks of using email to communicate sensitive medical information:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and be received by many intended and unintended recipients without your knowledge or agreement.
- Emails may be sent to the wrong address by any sender or receiver.
- Email is easier to forge than handwritten or signed papers.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- Email service providers have a right to archive and inspect emails sent through their systems.
- Email can be intercepted, altered, forwarded, or used without detection or authorization.
- Email can spread computer viruses.
- Email delivery is not guaranteed.
- Email can be used for Phishing. Phishing is a technique of obtaining sensitive personal information from individuals by pretending to be a trusted sender.