LEE HEALTH

PATIENT ACCESS REQUEST FOR MEDICAL RECORDS

Patient's Legal Name:_____ Date of Birth: _____

Telephone: (_____) _____

Address:_____

As provided by the Health Insurance Portability and Accountability Act ("HIPAA"), I am requesting that Lee Health provide me with access to my health information as described below. I understand that I will be contacted regarding the fees to be charged to fulfill this request and that I will have the opportunity to modify or withdraw my request if I do not want to pay those fees.

Type of Access Request. Check those that apply to the access request that you are making:

□ I request that a copy of my requested health information be provided to me by U.S. Mail at the address listed above.

□ I request that a copy of my requested health information be provided by U.S. Mail to a third person(s), whose name and address are as follows:_____
_____
_____.

□ I request that my requested health information be sent to me or a third party by electronic delivery (additional form to be completed.)

□ I request that my requested health information be delivered to my MyChart account.

□ I want to inspect (read) my Health Information on the Lee Health premises. Lee Health will contact you to determine a date, time and location convenient for you.

If by Mail, please indicate the format for the requested information: □ Paper or □ CD

Describe the Information Requested:

❑ 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 Request is for the following date(s) of treatment:

_____.

Patient:_____ Date: _____
Signature

Personal Representative*: _____ _____
Signature Print Name

_____ _____
Authority Phone Number

_____
Address

**If signed by a personal representative, please attach a copy of the document authorizing you to act on behalf of the patient.*

You may fax this form to (239) 343-4189 (Release of Information) or hand deliver to a Lee Health facility.

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 access request.

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 access request 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 Patient Access Request, 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.

REVIEW SECTION: (This section is to be completed by the Reviewer)

Date received:	**Reviewed by:**
Department Director:	**Review Date:**

Reviewer's Decision: Grant the Access Request _____ Deny the Access Request _____

Reviewer's Comments (Reason for Denial):

_____
_____
_____
_____
_____.

Extension of Deadline Request: □ Yes □ No

_____
Date

Reason for Extension:

_____

_____
Reviewer's Printed Name and Signature

_____
Date

If you disagree with our decision concerning your patient access request to your protected health information, you may send a written complaint to our Privacy Officer at P.O. Box 2218, Fort Myers, FL 33902, or e-mail at PrivacyOfficer@LeeHealth.Org. If you need assistance, you can call the Privacy Officer at (239) 343-8608.