COMMONWEALTH ORTHOPAEDIC ASSOCIATES

A division of Keystone Orthopaedic Specialists, LLC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ Social Security Number (last 4 digits)_____

Address:_____ City _____State_____ Zip_____

Date of birth:_____ Phone #s: Home _____ Cell _____ Work _____

I authorize a representative from **Commonwealth Orthopaedic Associates** to disclose the above-named individual's health information as directed below:

INFORMATION RELEASED TO: _____

Name of Company/ Agency/ Facility/ Person

*This section **MUST BE** complete or your request will not be processed.*

_____

Complete Street Address

_____

City, State, Zip Code

INFORMATION TO BE RELEASED:

☐ **Complete** medical record (p*lease specify dates of service*)_____

●●●●●● **-OR-**●●●●●●

☐ **Partial** medical record (*please specify below*)

Information	**Dates**	**Information**	**Dates**	
☐ *Office notes*	_____	☐ *Consultation reports*	_____	☐ *XRAY FILMS* (Done at COA)
☐ *Radiology reports*	_____	☐ *Discharge summaries*	_____	date_____
☐ *Laboratory reports*	_____	☐ *History & Physical*	_____	☐ *MRI FILMS* (Done at COA)
☐ *Operative reports*	_____	☐ *Emergency reports*	_____	date_____
☐ *Physical Therapy*	_____	☐ *Cardiology reports/tests*	_____	☐ ***Other***_____

NOTE: CIOX Health has been contracted to process your medical records request. There are fees involved with this service which are explained on the attached information page from CIOX Health. You will be invoiced directly from CIOX Health.
CIOX Health addresses our requests one time per week. This process will take a minimum of 7-14 days, so please plan your requests accordingly. We cannot accommodate requests within a shorter timeframe.

☐ I do ☐ I do **NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

PURPOSE OF REQUEST:

☐ Continuing care ☐ Personal copy ☐ Change of doctor ☐ Worker's comp ☐ Insurance
☐ Disability Determination ☐ Other_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is **valid for 1 year** from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of patient / legal guardian or Personal Representative of patient's estate **Date**

MEDICAL INFORMATION RELEASED CIOX

Entire_____ Lab_____ EKG_____ HP_____
DS_____ EKG_____ IMMUNE_____ PATH_____
OP_____ X-Ray_____ OTHER_____

_____
ROI SPECIALIST
# of pages_____ Date _____

Ciox Health is a contracted release of information vendor here at **Commonwealth Orthopaedic** in Health Information Management Services. Below are the standard fees for producing a copy of your medical records by Ciox.

Access Fees for PATIENTS ONLY:

- Electronic records delivered in electronic format $6.50
- Electronic medical record with paper records delivered in electronic format are billed at $6.50 + $0.07 per page labor cost to create and deliver the portion of the record maintained in paper
- Electronic records delivered in paper $0.90 labor cost to create and deliver the portion of the record maintained electronically plus $0.05 per page for paper and toner
- Paper records delivered in electronic format $0.07 per page labor fee
- Paper records delivered in paper $0.12 per page

Plus postage and taxes

CIOX Health does not accept cash.
An invoice will be mailed with the records.
Please allow up to 30 days for processing.