Medical Records Fees Notice

To Our Patients:

One of Florida Neurology Group's goals is to keep healthcare cost to a minimum. The processing of medical records requests requires additional resources. While this service has been a convenience to our patients the cost is excessive. Therefore, *Florida Neurology Group* has selected *CIOX Health* to process all medical records request.

CIOX Health is a HIPAA-certified release of information Service Company. For questions please call, *CIOX Health*, 800-367-1500.

If you request your records for personal use, your request will be processed through *CIOX Health at a rate of* $0.05 per page copying fee. You are also charged postage as the records will be mailed to you. For electronic medical records, CIOX can send an encrypted email with your records at a flat rate of $6.50. This is all permissible by Florida law. CIOX Health will send an invoice along with the release of records. This process can take anywhere from 7 – 10 days from the time the request is turned into CIOX Health.

If you request your records for continuation of care to another physician, or healthcare provider, Florida Neurology Group will process that request free of charge.

You may obtain some of your medical records from the patient portal, ***MyChart***. For more information about ***MyChart*** ask any FNG employee, they will be glad to help.

Florida Statue 64B8-10.003, states that a healthcare provider or contractor may charge a person who requests medical records a reasonable fee for the production of the records.

Risk 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 email, 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.
- Emails 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.

Electronic Record Delivery Request

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

Signature _____ Date**:** _____

FLORIDA Neurology Group
12670 Whitehall Drive, Fort Myers, Florida 33907
(239)936-3554 Fax(239) 936-8993

Pt Acct#_____

Dr. #_____

F/U Date_____

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to Florida Neurology Group and/or the provider listed below to disclose a copy of the specific health/medical information identified below:

RELEASING TO: (CIOX Health does not fax) ☐ Mail My Records ☐ Email My Records					
Name					
Address					
City		**State**		**Zip**	
Phone		**Fax**			
Email					
REQUESTING Records FROM:					
Name					
Address					
City		**State**		**Zip**	
Phone:		**Fax**			

For the Following Purposes:

☐	Continued Medical Care	☐	Personal Information	☐	Legal Follow-up
☐	Disability Insurance	☐	Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

☐	Please send the entire Medical Record (all information) to the above named recipient.				
☐	Office Notes and Reports	☐	Diagnostic Reports	☐	Billing Statements
☐	Rx History	☐	Transcribed Hospital Reports	☐	Laboratory Reports
☐	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases
_____ Mental Health Information and/or Records
_____ Domestic Violence
_____ Genetic Testing Information and/or records
_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:_____
_____ Other: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.
I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.
Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

Name of Patient:_____ _____ Date of Birth:_____ SS#_____
FIRST NAME (PRINT) LAST NAME (PRINT)

Signature of Patient or Legal Representative: _____ Date:_____

Print Name of Legal Representative (if applicable): _____ Relationship to patient: _____

For Office Use Only:
☐ Permission to release (verbal or written)
☐ Mail Records to address listed
☐ Faxed Request to HealthPort
Completed by:_____