Richmond Health Information Management Service Center (HSC) Release of Information

7300 Beaufont Springs Drive, Richmond VA 23225 • Phone: 877-302-7338 • FAX: 855-330-4290 (patient) • 855-226-6070 (physician) RICHSC.PHI@cioxhealth.com (For Patients Only)

Section A: This section must be completed for all Authorizations																
Patient Name:		Date of Birth: Patie						one:			Last 4 digit SSN (optional):					
Hospital's Name:	Recipient's Name:															
Hospital's Address:		Address 1:														
		Address 2:						Recipient's Phone:								
		City:							State: Zip:							
Request Delivery (If left blank, a paper copy will be provided): Paper Copy Electronic Media, if available (e.g., USB drive, CD/DVD), eDelivery Encrypted Email Unencrypted Email NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.																
Email Address (If email checked	above. Plea	ise print legib	iy):													
This authorization will expire on the	e following: <mark>(F</mark>	Fill in the Date	or the Ever	nt but not b	ooth.	<u>)</u>										
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: Event:																
Purpose of disclosure:																
Description of information to be used or disclosed																
Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.																
Description:	Date(s):	Description		ao many it		te(s		escri) ·				Dat	e(s):	
☐ All PHI in medical record		☐ Operative i		Du	iclo				ery sur	nmar						
☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake		☐ Cath lab☐ Special tes☐ Rhythm str☐ Nursing info	☐ OB nurs ☐ Postpar ☐ Itemizer ☐ UB-04:				ursing artum ed bi 4:	ing assess um flow sheet bill:								
☐ Clinical test ☐ Medication sheets		☐ Transfer forms ☐ ER information] Other:] Other:								
I acknowledge, and hereby conse	nt to such, the			n may con	tain a	alcoh				enetic ir	nform	ation.				
psychiatric, HIV testing, HIV result				(Initial)			,	Ü	. 0							
I understand that: 1. I may refuse to sign this author: 2. My treatment, payment, enrolln: 3. I may revoke this authorization revocation. Further details may 4. If the requester or receiver is no privacy regulations and may be 5. I understand that I may see and 6. I get a copy of this form after I see	nent or eligibili at any time in be found in the tot a health plate redisclosed. It dotted to be to be sign it.	ity for benefits writing, but if l ne Notice of Pr in or health can y of the inform	may not be I do, it will r vivacy Pract re provider, action descr	not have a tices. , the releas ribed on th	ny af sed ir is for	ffect of the form of the form of the form,	on any nation or a rea	actior may n asonal	ns tak o lonç ole co	en prio ger be p	oroted if I as	cted b	y fec			
Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.																
Will the recipient receive financial remuneration in exchange for using or disclosing this informat If yes, describe: May the recipient of the PHI further exchange the information for financial remuneration?							mation	ution? ☐ Yes ☐ No ☐ Yes ☐ No								
Section C: Signatures																
I have read the above and authorize the disclosure of the protected health information as stated.																
Signature of Patient/Patient's Representative:								ate:								
Print Name of Patient's Representative:								Relationship to Patient:								

Health ONE

Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Information/Label



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Hospital's Address:			Address 1:														
			Address 2:							Recipient's Phone:							
		City:								State	:		Zij	Zip:			
Request Delivery (If left blank, a paper copy will be provided): Paper Copy Electronic Media, if available (e.g., USB drive, CD/DVD), eDelivery Encrypted Email Unencrypted Email NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.																	
Email Address (If email checked	l above. P	lease prii	nt legibl	ly):													
This authorization will expire on the Date:	l ne following Event:	ı: (Fill in th	e Date	or the E	 Event	t but n	ot botl	h.)									
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Description:	Date(s)	: Desc	Description:				D	ate(s	s): D	escri	ptio	n:			Date(s):		
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical test ☐ Medication sheets		☐ Cat ☐ Spe ☐ Rhy ☐ Nur ☐ Tra	☐ Operative information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm strips ☐ Nursing information ☐ Transfer forms ☐ ER information					☐ Labor/deliver ☐ OB nursing a ☐ Postpartum f ☐ Itemized bill: ☐ UB-04: ☐ Other: ☐ Other:				g asse m flow	SS				
I acknowledge, and hereby conse	nt to such,				ation	may c	ontair	n alcol				enetic	inform	ation,			
psychiatric, HIV testing, HIV result	ts or AIDS	informatic	n		(Ir	nitial)											
 I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I get a copy of this form after I sign it. 																	
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Will the recipient receive financial remuneration in exchange for using or disclosing this information?																	
If yes, describe:	nformation for financial remuneration?					mation	□Yes □No										
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Print Name of Patient's Representative:								R	Relationship to Patient:								

Health

Authorization for Use and Disclosure of Protected Health Information (PHI)

Patient Information/Label

ROI 70788 (12/18)

White - Chart

Yellow - Patient