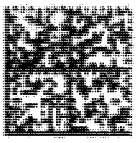
MD Anderson Cancer Center

Authorization for the Use and Disclosure of Protected Health Information (ROI)



PATIENT:
MDA MRN: DOB:
LOCATION:
PRINT DATE: 7/23/2018; SEX: FC:

Patient Name: _____ DOB: _____ MRN: _____
Patient Phone: _____ Email: _____

I authorize **MD Anderson Cancer Center** to disclose the following Protected Health Information from the medical record (including Proton Therapy Center records) of the patient named above to:

Name (person or organization): RECORDS DEPOSITION SERVICE, INC.
Address: PO BOX 5054, SOUTHFIELD, MI 48086-5054
Phone: 248-357-3330 Fax: 248-357-3337 Email: REQUESTS@RECDEP.COM

By: ☐ Fax ☑ Email ☐ Mail ☐ Hold *(patient pick up)* ☐ myMDAnderson **Format** ☐ Paper/Hard Copy ☑ Electronic

Information to be disclosed *(check all that apply)* for date range _____:

Health Information Management
- ☐ Entire Legal Medical Record
- ☐ ***Abstract of Record**** *(Includes items in bold/italics)*
- ☐ Cardiology Notes / Reports
- ☐ Chemotherapy Notes
- ☐ ***Consultation Notes***
- ☐ ***Diagnostic Imaging Notes/Reports***
- ☐ ***Discharge Summary***
- ☐ ***History/Physical (H&P)***
- ☐ Laboratory Tests
- ☐ Nurses Notes
- ☐ **Operative Reports**
- ☐ **Pathology Reports**
- ☐ ***Primary Medical Evaluation***
- ☐ Progress Notes
- ☐ Radiation Oncology Notes

Pathology
- ☐ All Pathology Records
- ☐ Slides
- ☐ Blocks
- ☐ Reports
- ☐ Other: _____

Other
- ☐ Billing Records *(available in paper format only)*
- ☐ Psychotherapy Notes
- ☐ Research Records
- ☐ Photographs/Videos
- ☐ FMLA, Disability, Return-to-work and/or Worker's Compensation forms and associated records/notes
- ☐ Other: _____

Diagnostic Imaging
Please specify item (e.g., recent X-ray):
_____
_____
_____
_____

Radiation Oncology
- ☐ Treatment Plan(s)
- ☐ Simulation Images
- ☐ Port Images
- ☐ Other: _____

Outpatient Pharmacy
- ☐ Prescription Records

I understand that sensitive information (such as, HIV/AIDS Treatment Records and Mental Health Records) may be disclosed unless prohibited here:

DO NOT DISCLOSE: ☐ Mental Health Records ☐ Genetic Information *(including test results)*
☐ HIV/AIDS Treatment Records ☐ Sexually-Transmitted Diseases ☐ Substance Abuse Treatment Records
☐ Other: _____

Note: ***It may not be possible to remove this information from billing or medical records when embedded in the text of some provider's notes. Release of Psychotherapy Notes (as defined by HIPAA) requires a separate written Authorization.***

I authorize disclosure of the information noted above for the following purpose(s):

☐ Personal Use ☐ Continuation of Care ☐ Work-related (FMLA, workplace accommodations) ☑ Legal/Litigation
☐ Payment/Insurance ☐ Worker's Compensation ☐ Research ☐ Disability Insurance
☐ Education (e.g., external presentations, publications) ☐ Other: _____

I understand this authorization will expire one (1) year from the date the authorization is signed, or upon the following date or event (specify): _____.

I understand that once disclosed, my information may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I may revoke this authorization in writing at any time, except when MD Anderson has already relied on this authorization or the information is no longer under MD Anderson's control. I can revoke this authorization by sending a written request to Privacy Officer, MD Anderson Cancer Center, Institutional Compliance Office, Unit 1640, PO Box 301407, Houston, TX 77230-1407, Phone: 713-745-6636, Fax: 713-563-4324 or at PrivacyCompliance@mdanderson.org.

This authorization is optional and I do not have to sign it. Refusing to sign will not affect my treatment or payment for services.

Signature of Patient or Legally Authorized Representative: _____
Printed Name of Signor: _____ Date/Time: _____
Legally Authorized Representative's Relationship to Patient *(check all that apply)*:
☐ Parent ☐ Guardian ☐ Other** *(specify)*: _____

Hospitals and providers may fax requests to 832-750-3013 & 1-855-884-3263. Patients may send requests by email: roi@mdanderson.org or U.S. Mail: 7007 Bertner Avenue, Unit 1632, Houston, TX 77030.

THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

Release of Information Fee Schedule

PATIENT:
MDA MRN: DOB:
LOCATION:
PRINT DATE: 7/23/2018; SEX: FC:

Patients requesting a copy of their medical records for continuation of care may have their records sent directly to another healthcare provider at no charge. If a patient is requesting to hand carry the records or retain a copy for his or herself, a fee is charged in accordance with state and federal law. MD Anderson Cancer Center's Release of Information services is handled by CIOX Health. CIOX accepts payments mailed to the address provided on the invoice or they accept payments over the phone by calling 1-800-367-1500. You may also pay online at www.healthportpay.com.

The Medical Record Copy fees are based on the form and format of the original health record. Your record at MD Anderson may be stored in an electronic health record or in paper format and some are both paper and electronic which is called a hybrid record.
The Ciox copy fees below are for Patients Only.

Fees for an electronic copy of your record	Fees for a paper copy of your record
If your original record is electronic and delivered via My Chart there is NO CHARGE. **When your original record is electronic and provided on CD:** • $6.50 flat fee for the electronic medical record copies • Plus sales tax as applicable **When your original record is in paper and you are requesting an electronic copy:** • $0.07 per page for the labor to convert the paper record to electronic format • Plus sales tax as applicable **When your record is Hybrid and you are requesting a CD or delivery via Ciox eDelivery portal:** • $6.50 flat fee for the electronic medical record copies • $0.07 per page for the paper record delivered to you electronically • Plus sales tax as applicable	**Records requested and picked up on site that are 20 pages or less are NO CHARGE.** **Records released to My Chart are NO CHARGE.** **If your original record is electronic:** • $0.90 base fee for labor to convert the electronic record to paper • $0.05 per page for supplies (paper and toner) • Plus Sales tax as applicable and actual postage and handling **If your record is maintained in paper and you are requesting a paper copy:** • $0.07 per page for labor to produce the paper copy • $0.05 per page for supplies (paper and toner) • Plus sales tax as applicable and actual postage and handling **If your record is Hybrid and you are requesting it to be delivered in paper:** • $0.90 base fee for labor to convert the electronic record to paper • $0.07 per page for labor to produce the paper copy • $0.05 per page for supplies (paper and toner) • Plus Sales tax as applicable and actual postage and handling

****LEGALLY AUTHORIZED REPRESENTATIVES & PROOF OF IDENTIFY**

The following individuals may authorize the release of records on behalf of a living adult patient:
- Agent appointed under a Medical Power of Attorney/Durable Power of Attorney for Health Care (when patient has been certified incompetent)
- Legal guardian (if patient has been certified incompetent) Attorney Ad Litem or Guardian Ad Litem
- Attorney retained by the patient or the patient's Legally Authorized Representative

The following individuals may authorize the release of records on behalf of a deceased adult patient:
- Executor, Administrator, or other court-appointed Personal Representative of the deceased patient's estate. If there is no Executor, Administrator, or court-appointed Personal Representative, then the following individuals, in this order:
  - Decedent's spouse
  - Adult children of the decedent
  - Adult grandchildren of the decedent
  - Parents of the decedent
  - Adult brothers and sisters of the decedent
  - Adult children of the brothers and sisters of the decedent
  - Adult grandchildren of the decedent's brothers or sisters
  - Grandparents of the decedent
  - Adult uncles or aunts of the decedent

The following may authorize the release of records for patients who are minors:
- Parent or legal guardian
- Person acting in loco parentis with legal authority to make decisions on behalf of the child
- When a custody decree exists, the parent(s) who can make health care decisions for the child

When requesting records, you may be asked to provide one or more of the following documents:
- Photo identification
- Proof that you are the Executor/Administrator/Representative of a deceased patient's estate
- Medical Power of Attorney accompanied by a Physician Statement
- Death Certificate and/or Birth Certificate
- Proof of Legal Guardianship/Custody

I have read and understand the above.

Name:_____ Date:_____