

Attention MD Anderson Patients:

Please use one of the methods listed below to obtain a copy of your medical record.

1. Request records via your MyChart account.
2. Email completed authorization form to ROI@mdanderson.org
3. Fax completed authorization form to 1-855-884-3253
4. Mail completed authorization form to 1515 Holcombe, Unit 1209, Houston, TX 77030.

Instruction for completing attached form:

- If you are requesting that your records to be sent to a physician's office or hospital for continuing care, please complete the Authorization for Disclosure of Health Information form. Once the completed form is received, a ROI Specialist will fax your records to the physician's office or hospital within 24 business hours (3 business days).
- If you are requesting your medical records for personal use and would like for records to be sent directly to you via **US Postal Service**, please complete Authorization for Disclosure of Health Information. Once the completed form is received, a ROI Specialist will complete your request within 7 to 10 business days. The process is the same for sending your records to third party requesters. **Please note that we cannot fax your records back to you, they must be mailed per HIPAA Privacy Rule.**
- If you are requesting your medical records for personal use and would like for records to be electronically delivered to you via email, please complete the authorization form. Once the completed form, is received, an ROI Specialist will complete your request within 7 to 10 business days. **Please note that we require a complete address for all requests regardless of the delivery method.**
- If you would like to get your records in person the Medical Records office is open from 8:00 am to 4:30pm, Monday through Friday, excluding observed holidays. You can complete Authorization for Disclosure of Health Information and receive your records at one of the following locations:

Lowry and Peggy Mays Clinic (ACB) 1200
Holcombe Blvd, Room ACB2.1613
Houston, Texas 77030

Main Building
1515 Holcombe Blvd, B3.4362
Houston, Texas 77030

**If you have any questions, please contact the Release of Information Dept.
@ 713-792-6710 and a ROI Specialist will be glad to assist you.**



PATIENT: _____
 MDA MRN: _____ DOB: _____
 LOCATION: _____
 PRINT DATE: 6/4/2020; SEX: _____ FC: _____

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

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): _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

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 <input type="checkbox"/> Entire Legal Medical Record <input type="checkbox"/> Abstract of Record* <i>(includes items in bold/italics)</i> <input type="checkbox"/> Cardiology Notes / Reports <input type="checkbox"/> Chemotherapy Notes <input type="checkbox"/> Consultation Notes <input type="checkbox"/> Diagnostic Imaging Notes/Reports <input type="checkbox"/> Discharge Summary <input type="checkbox"/> History/Physical (H&P) <input type="checkbox"/> Laboratory Tests <input type="checkbox"/> Nurses Notes <input type="checkbox"/> Operative Reports <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Primary Medical Evaluation <input type="checkbox"/> Progress Notes <input type="checkbox"/> Radiation Oncology Notes	Pathology <input type="checkbox"/> All Pathology Records <input type="checkbox"/> Slides <input type="checkbox"/> Blocks <input type="checkbox"/> Reports <input type="checkbox"/> Other: _____ Other <input type="checkbox"/> Billing Records (available in paper format only) <input type="checkbox"/> Psychotherapy Notes <input type="checkbox"/> Research Records <input type="checkbox"/> Photographs/Videos <input type="checkbox"/> FMLA, Disability, Return-to-work and/or Worker's Compensation forms and associated records/notes <input type="checkbox"/> Other: _____	Diagnostic Imaging Please specify item (e.g., recent X-ray): _____ _____ _____ _____
		Radiation Oncology <input type="checkbox"/> Treatment Plan(s) <input type="checkbox"/> Simulation Images <input type="checkbox"/> Port Images <input type="checkbox"/> Other: _____
		Outpatient Pharmacy <input type="checkbox"/> 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 1-833-768-3703 & 1-855-884-3253. Patients may send requests by email: roi@mdanderson.org or U.S. Mail: 1515 Holcombe Blvd, Unit 1209, Houston, TX 77030.



PATIENT:
 MDA MRN: DOB:
 LOCATION:
 PRINT DATE: 6/18/2020; SEX: FC:

Release of Information Fee Schedule

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
<p>If your original record is electronic and delivered via My Chart there is NO CHARGE.</p> <p>When your original record is electronic and provided on CD:</p> <ul style="list-style-type: none"> ● \$6.50 flat fee for the electronic medical record copies ● Plus sales tax as applicable <p>When your original record is in paper and you are requesting an electronic copy:</p> <ul style="list-style-type: none"> ● \$0.07 per page for the labor to convert the paper record to electronic format ● Plus sales tax as applicable <p>When your record is Hybrid and you are requesting a CD or delivery via Ciox eDelivery portal:</p> <ul style="list-style-type: none"> ● \$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 	<p>Records requested and picked up on site that are 20 pages or less are NO CHARGE. Records released to My Chart are NO CHARGE.</p> <p>If your original record is electronic:</p> <ul style="list-style-type: none"> ● \$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 <p>If your record is maintained in paper and you are requesting a paper copy:</p> <ul style="list-style-type: none"> ● \$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 <p>If your record is Hybrid and you are requesting it to be delivered in paper:</p> <ul style="list-style-type: none"> ● \$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