HIM ROI Authorization

PLEASE RETURN TO:
Children's of Alabama, HIM Dept.
1600 7th Avenue South
Birmingham, Alabama 35233
ROI Phone: (205) 638-9728
ROI Fax: (205) 638-2291
Continuity of Care Phone: (205) 638-2425
Continuity of Care Fax: (205) 638-5367

Children's of Alabama

Patient Label

AUTHORIZATION FOR RELEASE OF INFORMATION

Please include copy of your picture ID

Patient Name (Last, First, MI):_____

Address: _____

Phone Number: (_____) _____Date of Birth: _____

This Authorization applies to the following Information:

☐ **Abstract [Emergency Department, Discharge Summary, History and Physical, Operative Reports/Procedure Reports, Pathology Results, Consultation Reports, Radiology Reports, EKG/Cardiology Reports].**

I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive health information and I expressly consent to the release of the information.

☐ ***Only*** the following records or types of information: _____

_____

Treatment Dates: from (month/day/year) ____/_____/____ to (month/day/year) ____/____/_____

Please mark if you would like to include also:

☐ Immunizations (Please note this is available via patient portal. These will only be present if you received immunization at COA)

☐ Lab Results (Please note this is available via patient portal. Cost-based fee apply. Please read pricing policy)

☐ Flowsheets (High page count, cost-based fee apply. Please read pricing policy)

☐ Progress Notes (High page count, cost-based fee apply. Please read pricing policy)

The Information may be released as follows:

☐ **From: Children's of Alabama**
1600 7th Avenue South
Birmingham, AL. 35233

To: _____
_____
_____

OR ----------

☐ **From:** _____
_____
_____

To: Children's of Alabama
1600 7th Avenue South
Birmingham, AL 35233

Purpose of the release: _____

☐Continuity of Treatment ☐ Other *(Please specify):*_____

I understand the Information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of Information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from Medical Information Services. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the Information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical record copies, please ask about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the Information to be released as described above.

_____ _____
Patient/Parent/Legal Guardian Printed Name | Parent/Legal Guardian Signature | Date

_____ _____
Patient Signature if 19 or older | Date | Witness Signature for Patient/Parent/Legal Guardian | Date

HIM ROI Authorization

Children's of Alabama

Patient Label

Release of Information Guidelines

What You Need to Know About Requesting Copies of Medical Records

THIS FORM MUST BE RETURNED WITH THE AUTHORIZATION

1. The authorization must be:
   a. Completed in full
   b. Completed in black or blue ink
   c. Addressed to Children's Hospital of Alabama
   d. Signed by the patient if:
      i. The patient's age today is 19 years or older **-OR-**
      ii. The patient is an Emancipated Minor (married, divorced or born a child)
         - Females under the age of 19 years who are pregnant or who have borne a child can authorize the release of medical records of their child.
   e. Signed by either of the patient's parents or the patient's legal guardian if the patient is under the age of 19 years. A copy of the parent's driver's license is required. ***If the requesting parent's name is not in the child's record, a copy of the birth certificate must be presented to establish parental relationship.***
   f. The following legally applies to Alabama MEDICAID patients for all casualty and litigation cases:
   Health Management Systems (HMS) is under contract with Alabama Medicaid to process the "Request for Medical Records" and perform the evaluation and case tracking functions of all casualty and litigation cases. Medical record request forms are to be faxed to HMS at 866-274-5974. To contact HMS by phone regarding a medical record request or for information related to a casualty or litigation case, you may reach HMS at 877-252-8949. https://www.medicaid.alabama.gov/

2. Copying Charges Policy
   a. Alabama Code Section 12-21-6.1 "Reproduction and Delivery of Medical Records" established a fee schedule for charges incurred for copying medical records:
      i. $0.12 Flat Rate per page
   b. Alabama Code Section 12-21-6.1 reasonable costs may be allowed for production of a CD.
   c. $6.50 Flat rate if transferred electronically from the DMS/EMR to CD
   d. Exceptions to these fee schedules are noted by PRO contracts and Disability Determination Services standard fee payment.
   e. Patients are not charged a search and retrieval fee.
   f. No charge is made for continued care requests received from other health care providers (i.e. hospitals, physician offices, clinics, etc.)
   g. An invoice, reflective of the above schedule, is prepared when records are copied. Copies and invoicing services are provided by CIOX Health.
3. Definitions
   a. **CD** – Compact Disc
   b. **PRO** – Peer Review Organization
   c. **DMS** – Document Management System
   d. **EMR** – Electronic Medical Record

By signing this form I acknowledge that I have read the above and have no further questions about the information listed.

Printed Name _____ Date _____ Signature _____

How may we contact you?

Telephone: Home _____ Work _____

Cellular _____ Other _____