Mary Washington Orthopedics
in affiliation with FOA

3310 Fall Hill Avenue
Fredericksburg, VA 22401
P 540.373.4602 **F** 540.310.0100

MEDICAL RECORD AND X-RAY REQUEST

PLEASE PRINT

Date: _____

Patient: _____

Patient's Address: _____

City_____

Patient's Date of Birth: ____/____/____ Patient's SS#: _____-_____-_____

Medical records and/or x-rays are being requested on the above-named patient. The patient and or the patient's guarantor are responsible for the cost of each set of reproduced medical records and or x-rays. All copies requested and processed, will be charged to your account. The reproduction fees are as follows:

- Mail delivery: Paper copies 12 cents per page
- Email delivery: $6.50 plus tax - flat rate
- Mail delivery of x-ray on CD: $6.50 – flat rate

The cost of the postage to mail medical records is charged to the patient/guarantor. Please see the option below to receive medical records electronically. If the patient requests medical records to be sent to a third party, the patient will be responsible for the cost of the medical records.

We require a minimum of 15 days to process your request.

Reason for request (please check the box that applies):

☐ Patient Use ☐ Attorney ☐ Insurance (including compensation of disability)

☐ Other Physician Requested ☐ Other_____

Send Records to:_____

Address_____

Phone: _____

This request is for: (check below)

☐ CD of x-ray(s) only

Medical Records Only: (check below)

☐ All Medical Records ☐ Only those records notated below

_____

Ciox Health processes all medical records requests. To receive your records as an electronic PDF file via email please request and complete the Electronic Record Delivery Request form along with a HIPAA Authorization. Otherwise, the requested medical records will be mailed to the stated address on this form. You may contact Ciox to inquire about your request at 1-800-367-1500 or www.cioxhealth.com.

Signature Patient/Legal Guarantor

X_____**(Phone #)**_____

MW Ortho Initials_____

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You have requested an electronic copy of your medical records.

Ciox will, under agreement with this healthcare provider, facilitate the release of your records based on your authorized request.

You will receive an email from Ciox, at the email address you have provided on the Electronic Record Delivery Request form, which will include detailed instructions on how to access your electronic records via a secure web portal. Once you have received the email notification from Ciox, the medical record will be available via the web portal for 30 days. If the record is not accessed during that timeframe, it will be deleted from the portal. If you need the record after that time, you must resubmit your request to the healthcare facility.

To access the record electronically you will need to be able to access a computer with a web browser. You will need Adobe Reader (free) to view the PDF files. If you would like to print the files, you will also need access to a printer.

If you have any questions or to check on the status of the medical record request, please call Ciox directly at (800) 367-1500.

Thank you.

Patient Name: _____ **Patient DOB:** _____

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Patient Name: _____ **Date of Birth:** _____

Daytime Phone Number: _____

I have requested a copy of my medical records and understand Ciox will, under agreement with Mary Washington Orthopedics in affiliation with FOA, facilitate the release of my records based on my authorized request.

I understand I will receive an email from Ciox, at the email address provided below, that will include detailed instructions on how to access my electronic records via a secure web portal. Once I have received the email notification from Ciox, the medical record(s) will be available via the web portal for 30 days.

Email address for record delivery: _____

List any exceptions unavailable for release: _____

_____

_____

The patient has the right to revoke this authorization. In order to be effective, it must be in writing. The revocation will take effect on the date both the patient and the practice have signed it. It must include patient's name, address, and phone number. The patient's reason for revocation, the patient's signature, and the date of revocation must be included.

Mary Washington Orthopedics in affiliation with FOA will accept revocations of this authorization by certified mail only. This revocation must be sent to the attention of the Privacy Officer, Debbie Catlett, at Mary Washington Orthopedics in affiliation with FOA, 3310 Fall Hill Ave., Fredericksburg, VA 22401. It is not effective until received and signed by the Privacy Officer. I fully understand and accept the terms of this authorization.

I also acknowledge receipt of the notice of Information Practices provided to me.

_____ _____

Patient or Legal Guardian Date

_____

MRN