Medical Record Request Information

Shady Grove Fertility has partnered with CIOX Health the nation's largest provider of release of medical information services, to process and fulfill your request for a copy of your medical record.

Due to the strict procedural and highly regulated steps involved in this process, known as the release of information process, there are costs associated and, therefore, a fee for all patient requests for medical records, based on state and federal law.

These rates are:
$6.50 Flat Fee + Sales Tax for an Electronic Copy of your Records
$0.12 per page + $0.90 Processing Fee + Sales Tax + Postage for a Mailed Copy of your Records

Per HIPAA regulations please allow up to **30 days from the date of receipt** in the Medical Records Dept. for your medical record request to be processed.

Due to HIPAA regulations release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, genetic testing, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse can only be released with your consent therefore you **must initial** if you require this information.

If requesting your records and your partner's records please submit a separate medical record release request form with separate email addresses.

Completed Medical Record Release can be faxed to 1-855-309-0287, dropped off at the front desk, mailed to the address located on the form, or emailed to SGFmedicalrecords@sgfertility.com.
****Please note emailed requests are to submit record release forms only - it is an unmonitored mailbox with an auto reply message. Please do not email to check the status of your requests.**

Records delivered electronically will be sent from IOD Incorporated/CIOX Health. You will receive two emails. Please check your junk/spam mail.

For Customer Service or Billing Inquiries please contact CIOX Health customer service: 1-800-367-1500.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (PHI)

shady grove fertility

9600 Blackwell Rd., Suite 500, Rockville, Maryland 20850
Phone: 301-545-1417 Fax: 855-309-0287 Email: sgfmedicalrecords@sgfertility.com

_____ _____
Patients Full Name (please print) Date of Birth (Mo/Day/Year)

_____ _____
Street Address Social Security Number

_____ _____
City, State, Zip Code Phone (Daytime)

At the request of the individual, I _____, do hereby authorize **Shady Grove Fertility**
(Patient Name)
to release records for the time period dating from_____ to _____:

_____ HISTORY & PHYSICAL	_____ULTRASOUND REPORTS	_____STIM GRIDS
_____ PROGRESS NOTES	_____LABORATORY REPORTS	_____EMBRYOLOGY REPORTS
_____ CONSULTATION NOTES	_____RADIOLOGY REPORTS	_____ENTIRE MEDICAL RECORD (includes all above-no US images)
_____ OPERATIVE REPORTS	_____PATHOLOGY REPORTS	OTHER_____

_____ I DO ____ I DO NOT authorize release of HIPAA protected information related to AIDS or HIV infection, sexually transmitted diseases, genetic testing, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.
(PLEASE INITIAL ONE ABOVE)

INFORMATION RELEASE TO:
**Records can only be mailed to Physician's office, not emailed.
If a patient email address is provided the records will SOLELY be sent via email.

_____
NAME of Company/Agent/Facility/Person

_____
Street Address

_____
City, State, Zip Code

_____
Phone Number

EMAIL DELIVERY: (PROVIDE EMAIL ADDRESS ONLY IF SELF/PATIENT IS RECIPIENT):

_____

PURPOSE OF DISCLOSURE: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. **CIOX Health will not maintain the images beyond 30 days-subject to additional fees**. I understand that the information used or disclosed may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorized the use or disclosure of protected health information.

_____**(By signing this form you are agreeing to the fee below)** _____/_____/_____
Signature of individual or guardian or Personal Representative of patient's estate **Date**

NOTE: There is a charge of $6.50 flat fee for all records delivered electronically or $0.12 cents per page + $0.90 processing fee + tax + postage for records delivered via mail. CIOX Health has been contracted to provide this service and will invoice you directly. Please do not send payment to SGF. Please allow up to 30 days for records to be processed.