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

PATIENT:
MDA MRN: DOB:
LOCATION:
PRINT DATE: 7/11/2023; SEX: FC:

Authorization for the Use and Disclosure of Protected Health Information – Release of Information

A copy of this form must be given to the signing individual.

Patients may send requests via MyChart.
Requests may be sent by fax to 1-855-884-3253, email to roi@mdanderson.org or by mail to 1200 Pressler St, Unit 1209, Houston, TX 77030

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

Address: _____ **City, State, Zip:** _____

Telephone: _____ **Patient Number:** _____

I authorize The University of Texas **MD Anderson Cancer Center (MD Anderson)** to disclose the following protected health information (PHI) from the medical record of the patient named above to:

Name (person or organization): _____

Address: _____

Phone: _____ Fax: _____ Email: _____

By: ☐ Fax ☐ Email ☐ Mail ☐ Hold (patient pickup) ☐ MyChart **Format:** ☐ Paper/Hard Copy ☐ Electronic

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

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 Records
- ☐ Radiation Oncology Notes

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

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

Diagnostic Imaging
Please specify (e.g., recent X-ray):
_____
_____
_____
Format ☐ CD/DVD ☐ Paper

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

Outpatient Pharmacy
- ☐ Prescription Records

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
- ☐ Worker's Compensation
- ☐ Insurance
- ☐ Research
- ☐ Education (e.g., external presentations, publications)
- ☐ Other: _____

I understand that the information released may contain information related to AIDS or HIV infection, drug or alcohol abuse, mental or behavioral health or psychiatric care (other than psychotherapy notes) and authorize release of such information.

I understand this authorization will expire the later of 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 by mail to Privacy Officer, MD Anderson Cancer Center, Institutional Compliance Office, Unit 1640, PO Box 301407, Houston, TX 77230-1407, by fax to 713-563-4324, or by email to privacy@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.

PATIENT OR PERSONAL REPRESENTATIVE:

Is this consent being signed by the patient? ☐ Yes ☐ No

Printed Name of Patient or Personal Representative: _____

Signature: _____ Date: _____

Personal Representative's Authority (check all that apply): ☐ Parent ☐ Guardian ☐ Other (specify) _____

Is this consent being translated to the patient or the patient's personal representative? ☐ Yes ☐ No

Language: ☐ Arabic ☐ Mandarin ☐ Spanish ☐ Other (specify) _____

Print Translator First and Last Name: _____

Translator Signature: _____ Translator ID: _____

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

PATIENT:
MDA MRN: DOB:
LOCATION:
PRINT DATE: 10/25/2023; 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
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

Do Not File in Sanned Medical Record