St David's | North Austin Medical Center MyHealthOne CIOX Health

St David's | Surgical Hospital

MyHealth*One* Portal

Patients of St. David's North Austin Medical center can access their patient information 24/7 through the MyHealth*One* Portal http://stdavids.com/myhealthone.com

If you need assistance with MyHealth*One,* support is available 8:00am- 10:00pm CT Monday- Saturday
(855) 422-6625

Do you plan to order medical records from this facility? This medical facility utilizes the services of CIOX Health to handle the fulfillment of all requests for medical records. If you choose to request your records from this facility please know that CIOX Health will be processing and fulfilling your request.

Who is CIOX Health? CIOX Health is the premier provider of health information services and solutions. With a team of more than 3,500 employees, CIOX Health processes over 45,000 medical record requests daily for well over 10,000 healthcare facilities across the nation.

How do I request a copy of my records from this facility? Simply complete an authorization for release of your records at the facility, and CIOX Health will handle the rest. Please do not attempt to contact CIOX Health to request your records. **Your authorization and a copy of your picture ID must be sent directly to the medical facility or to our central processing center located in San Antonio.**

Please submit requests for medical records to:
HCA Shared Service Center
ATTN: Release of Information, CIOX Health
6000 N.W. Parkway Ste. 124
San Antonio, TX 78249

How do I receive my medical records?

Paper copies- CIOX Health will send your records to the recipient address listed on the signed Release of Information authorization form
eDelivery- Records will be delivered to a secure portal. The recipient listed on the signed Release of Information Authorization form will receive an email with the portal link and instructions on how to access the medical records requested.

Is there a fee for copies of medical records? There is no charge for copies of medical records that are released directly to your physician or healthcare provider or records that are requested for your personal use.

When should I expect my records to be delivered? Processing is typically 7-10 business days. If you would like your records for follow up care with your physician, please provide the doctor name, phone number, and fax as the receipt on the authorization.
If you have any further questions, please visit our Web site at www.cioxhealth.com or you may contact us at service@cioxhealth.com or local office 210-581-4585.

The check the status of a request please call 210-581-4585

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RELEASE/DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all authorizations

PATIENT INFORMATION	FOR OFFICE USE ONLY	
PATIENT'S NAME:	MR No.:	ACCT No.:
ADDRESS 1:	DOS:	LOCATION
ADDRESS 2:	COMMENTS/COMPLETION DATE:	
CITY, STATE, ZIP:		
BIRTH DATE:		
LAST 4 DIGITS OF THE SSN: (Optional)		
CONTACT NUMBERS:		

	FACILITY FROM WHICH PHI WILL BE RELEASED *(Check all that apply)*	DATES OF SERVICE
	North Austin Medical Center	
	St. David's Surgical Hospital	
	Other	

FACILITY/PERSON TO WHOM PHI WILL BE RELEASED/DISCLOSED:

NAME:
ADDRESS 1:
ADDRESS 2:
CITY, STATE, ZIP:
CONTACT NUMBERS:

PURPOSE OF DISCLOSURE: *(Note: **Indicates Fee for Copies)*

	Follow Up Care
	Personal Use
	Other** Please Explain

Request Delivery (If left blank, a paper copy will be provided):

☐ Paper Copy ☐ Electronic Media, if available (e.g., USB drive, CD/DVD, email)

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risk (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

INFORMATION TO BE USED/DISCLOSED: ***(Check all that apply)***

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below.

☐ **Pertinent Package**	☐ Cath Lab	☐ Imaging Films	☐ Nursing Information	☐ Consultations
☐ Front Sheet	☐ EKG, EEG, EMG	☐ Pathology Report	☐ Medication Records	☐ Complete Copy
☐ Discharge Summary	☐ Laboratory Report	☐ Pathology Slides	☐ Therapy Notes	☐ Immunization Record
☐ History/Physical	☐ ER Information	☐ Physician Orders	☐ Psychiatric Evaluations/Tests	☐ Other:__________
☐ Operative Report/Procedure	☐ Imaging Reports (X-rays, CTs, MRIs)	☐ Progress Notes	☐ Infections Disease (including HIV Test Results)	__________

If this authorization is for the disclosure of genetic information, please describe:____________________

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. Medical Information is considered Protected Health Information (PHI) under both Federal and State Privacy Laws.
4. Unless otherwise specified, this authorization shall expire 180 days from the date of my signature, OR from the date of discharge, whichever is later. (Otherwise specified date____________________)
5. I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, genetic information, HIV testing, HIV results or AIDS information.
6. A facility may not condition the provision of treatment to an individual on signing an authorization except for:
   1. Research-related treatment; and
   2. Health care that is solely for the purpose of creating information for disclosure to a third party.
7. I may revoke an authorization in writing except to the extent that;
   1. The facility has taken action prior to receiving the revocation; or
   2. If an authorization was obtained as a condition of obtaining insurance coverage. Further details may be found in the Notice of Privacy Practices.
8. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
9. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. There is a fee for copy services rendered.

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient or Authorized Party:	**Date:**
Witness (if applicable):	**Witness (If Applicable):**
Print Name of Patient or Authorized Party:	**Relationship to Patient:**

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