MyHealth*One* Portal
Patients of St. David's Healthcare 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
(PH) 1-210-581-4585
(FX) 1-210-581-4921
You can also find our authorization online, at http://www.stdavids.com

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.
Electronic Media- Ciox Health will provide records via CD with password encryption protection.

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.

To check the status of a request for copies of medical records, please call 210-581-4585

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FORM (1/2)

REV. 03/2017

Section A: This section must be completed for all Authorizations (Texas)

Patient Name:	**Birth Date:**	**Patient's Phone:**	**Last 4 digit SSN (optional):**
Provider's Name: South Austin Medical Center	**Recipient's Name:**		
	Address 1:		
Provider's Address: 901 W Ben White Blvd. Austin, Texas 78704	**Address 2:**	**Recipient's Phone:**	
	City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.,* USB drive, CD/DVD)**
☐ **Encrypted Email** ☐ **Unencrypted Email**

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

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 risks (*e.g.,* virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**
Unless a shorter time period is specified, this authorization will expire 180 days after the date it is signed.

Purpose of disclosure:

Description of information to be used or disclosed

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. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record ☐ Admission form ☐ Dictation reports ☐ Physician orders ☐ Intake/outtake ☐ Clinical test ☐ Medication sheets		☐ Operative information ☐ Cath lab ☐ Special test/therapy ☐ Rhythm strips ☐ Nursing information ☐ Transfer forms ☐ ER information		☐ Labor/delivery summary ☐ OB nursing assess ☐ Postpartum flow sheet ☐ Itemized bill: ☐ UB-04: ☐ Pertinent Package: ☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)
If this authorization is for 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. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. 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 redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

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 in 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/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FORM (2/2)