Acknowledgement of Medical Record Request Processing Fee

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows a fee (whether regulatory or statutory) to be associated with medical record request processing, excluding those that are needed for continuing care purposes.

Orthopedic Associates of Wisconsin has partnered with CIOX Health to process and fulfill your request for a copy of your medical record. The fee charged is detailed below:

Produced\Requested Medium and Cost		
Format of Original Patient Record	**Cost for delivery in electronic format (CD/USB/download or portal):**	**Cost for record delivered in Paper**
Electronic or Hybrid (part electronic part paper)	• $6.50 flat fee for electronic portion • Plus, if applicable, $0.07 per page for CIOX Health's labor cost to create and deliver the portion of record maintained in paper • plus sales tax as applicable	• $0.07 per page for CIOX Health's labor cost to create and deliver the portion of record maintained in paper • Plus, if applicable, the lower of cost under state regulated patient rates or $0.90 for CIOX Health's average labor cost to create and deliver the portion of record maintained electronically • Plus $0.05 per page for supplies (paper and toner) • Plus actual postage if mailed • plus sales tax as applicable
Paper	• $0.07 per page for CIOX Health's labor cost to create and deliver the portion of record maintained in paper Plus actual postage if mailed • plus sales tax as applicable	• $0.07 per page for CIOX Health's labor cost to create and deliver the portion of record maintained in paper • Plus $0.05 per page for supplies (paper and toner) • Plus actual postage if mailed • plus sales tax as applicable

By signing below, I acknowledge that I am aware of the fee that will be billed to me for requesting a copy of my medical record. I agree to pay this fee when services are rendered and I receive an invoice from HealthPort Technologies.

Name: ______________________________Phone #:______________________________

Address: ____
Street City State Zip

Patient Signature:____ Date: _____________________
(Or authorized representative)

Email address for electronic delivery request for medical record:

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The fee should be remitted to HealthPort Technologies as directed on the invoice you receive.

Please note that there is no fee for medical record requests sent directly to a physician or healthcare facility for continuing care purposes. There is no charge for patient's records up to 10 pages.

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