925 North Point Parkway, Suite 350
Alpharetta, GA 30005
(800) 367-1500
CIOXHEALTH.COM

Electronic Record Delivery Request

Complete this form, along with a HIPAA Authorization, to receive your medical records as electronic PDF files rather than as printed copies.

Requester Name			
	First	Last	
Street Address			
	Street	Suite / Apt #	
	City	State	Zip
Email Address for record delivery			
Medical Records Requested			
Patient Name			
	First	MI	Last
Date of Birth			
Date of Service			
	From	To	

Please provide me with the medical records described above through the Ciox eDelivery online service. I understand and agree that:

- I must provide a valid email address, either my own or that of my designated recipient.
- My records will be provided as Adobe PDF files on Ciox Health's **eDelivery** website.
- I will receive an email from **CioxHealth.com** containing instructions for accessing my records.
- There may be a fee for collecting my records. If so, an invoice will be included with the records.

Signature _____ Date**:** _____

FOR GREATER HEALTH