# SB 173 – Medical Records Amendments

The purpose of this legislation is to allow patients access to their medical records, at a reasonable cost, whether requested directly by the patient/individual, or through their designated legal representative/attorney.

This bill will allow individuals access to their personal medical records, which they legally entitled to, whether requested by themselves or their legal representatives/attorneys, as follows:

- Provides to *all other individuals* one **electronic copy** at a flat fee of \$25.00, regardless of whether it is requested by the patient/individual or their legal representatives/attorneys.
  - Currently, medical providers can charge by the page for electronic medical records, even though they don't keep physical files, are not printing the pages, and do not have to photocopy the record page by page.
  - O Today most, if not all, medical providers already have all their records available in electronic format and can make them available for a patient at the push of a few buttons.
- Prohibits medical record retrieval companies from taking advantage of the system by charging
  excessive fees for medical records when only requested in electronic format and when the request
  comes from a legal representative/attorney.
- Provides to "needs based" individuals one free copy of their electronic medical records each calendar year.
  - Need based individuals include Social Security disability and indigent claimants who are unable to pay for a medical records fee.
  - o In some cases, Social Security disability claimants cannot get medical records because of costs and are unable to get an attorney for representation for lack of medical records.

## **Background**

Individuals have a legal right to their medical records, sometimes referred to as "protected health information" or "PHI". Historically, when records were requested by a patient or their legal representative, a medical records custodian would have to locate the physical file and photocopy the same, at great time and expense. With modern technology, the vast majority of records are now kept electronically facilitating quick and efficient retrieval. Rather than photocopying hundreds/thousands of pages one at a time, the same medical records can now be easily placed on a CD or e-mailed to the patient.

Medical records are often required for individuals to make legal claims. In many cases, the injured and/or disabled are physically unable to request their medical records themselves. While a patient/individual can typically request their medical records free of charge, a myth has been perpetuated by medical record retrieval companies that if the request is made by a legal representative/attorney, it is okay for the legal representative/attorney to be charged significant amounts of money. But the legal representative/attorney is then forced to pass the costs associated with obtaining these records onto the patient/client.

P.O. Box 409740 Atlanta, Georgia 30384-9740 Fed Tax ID 58 - 2659941 1-800-367-1500



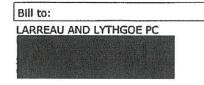
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Date:

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Customer #:

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Records from:

INTERMOUNTAIN HEALTHCARE 4646 W LAKE PARK BLVD WEST VALLEY CITY,UT 84120-8212

Requested By: Patient Name:

MOUNTAIN VIEW LAW GROUP

DOB:

| Description             | Quantity         | Unit Price | Amount |
|-------------------------|------------------|------------|--------|
| Basic Fee               |                  |            | 21.61  |
| Retrieval Fee           |                  |            | 0.00   |
| Per Page Copy (Elect) 2 | 40               | 0.27       | 10.80  |
| Per Page Copy (Elect) 1 | 2729             | 0.17       | 463.93 |
| Subtotal                |                  |            | 496.34 |
| Sales Tax               | 1                |            | 35.98  |
| Invoice Total           |                  |            | 532.32 |
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Terms: Net 30 days

Please remit this amount : \$532.32(USD)

Ciox Health

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Get future medical records as soon as they are processed, by signing up for secure electronic delivery. Register at: https://edelivery.cioxhealth.com

| Invoice #: |          |
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| Check #    |          |
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# Please return stub with payment.

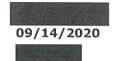
Please include invoice number on check.

P.O. Box 409740 Atlanta, Georgia 30384-9740 Fed Tax ID 58 - 2659941 1-800-367-1500

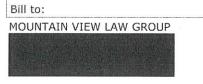


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Date: Customer #:



| MOUNTAIN VIEW LAW GROUP |
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Records from:

OGDEN REGIONAL MEDICAL CNTR 5475 SOUTH 500 EAST OGDEN,UT 84405

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MOUNTAIN VIEW LAW GROUP

DOB:

Patient Name:

| Terms: Net 30 days           | Please remit this amou | int : \$306.20(USD) | <del>)</del> |               |
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| balance Due                  |                        |                     |              | 306.20        |
| Invoice Total<br>Balance Due |                        |                     |              | 306.20        |
| Sales Tax                    |                        |                     |              | 20.70         |
| Subtotal                     |                        |                     |              | 285.50        |
| Electronic Data Archive Fee  |                        |                     |              | 2.00          |
| Per Page Copy (Elect) 1      |                        | 1477                | 0.17         | 251.09        |
| Per Page Copy (Elect) 2      |                        | 40                  | 0.27         | 10.80         |
| Basic Fee<br>Retrieval Fee   |                        |                     |              | 21.61<br>0.00 |
| Description                  |                        | Quantity            | Unit Price   | Amount        |

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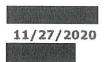
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P.O. Box 409740 Atlanta, Georgia 30384-9740 Fed Tax ID 58 - 2659941 1-800-367-1500



Involce #: Date:

Customer #:



Ship to:

LOWRANCE LUNDELL LOFGREN LOWRANCE LUNDELL LOFGREN 1099 W SOUTH JORDAN PKWY SOUTH JORDAN,UT 84095-8809 Bill to:

LOWRANCE LUNDELL LOFGREN LOWRANCE LUNDELL LOFGREN 1099 W SOUTH JORDAN PKWY SOUTH JORDAN,UT 84095-8809 Records from:

INTERMOUNTAIN HEALTHCARE 4646 W LAKE PARK BLVD WEST VALLEY CITY,UT 84120-8212

Requested By:

LOWRANCE LUNDELL LOFGREN

DOB:



Patient Name:

Per your request, please let this serve as your fee approval notice for medical records requested from the facility listed above. If you would like to approve this amount please contact a Ciox Health representative at 800-367-1500. If you would like to pay electronically, please go to https://paycioxhealth.com/pay/.

| Description              | Quantity            | Unit Price   | Amount                       |
|--------------------------|---------------------|--|------------------------------|
| Basic Fee                |                     |  | 21.61                        |
| Retrieval Fee            |                     |  | 0.00                         |
| Per Page Copy (Paper) 2  | 40                  | 0.54   | 21.60                        |
| Per Page Copy (Paper) 1  | 1624                | 0.33   | 535.92                       |
| Shipping<br>Subtotal     |                     |  | 61.88<br>641.01              |
| Sales Tax                |                     |  | 41.99                        |
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## Ciox Health

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Please include invoice number on check.

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INTERMOUNTAIN HEALTHCARE 4646 W LAKE PARK BLVD WEST VALLEY CITY,UT 84120-8212

Requested By: Patient Name:

LOWRANCE LUNDELL LOFGREN

DOB:

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| Description             | Quantity           | Unit Price | Amount |
|-------------------------|--------------------|------------|--------|
| Basic Fee               |                    |            | 21.61  |
| Retrieval Fee           |                    |            | 0.00   |
| Per Page Copy (Paper) 2 | 40                 | 0.54       | 21.60  |
| Per Page Copy (Paper) 1 | 1737               | 0.33       | 573.21 |
| Shipping                |                    |            | 63.21  |
| Certification Fee       |                    |            | 10.00  |
| Subtotal                |                    |            | 689,63 |
| Sales Tax               |                    |            | 44.69  |
| Invoice Total           |                    |            | 734.32 |
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## Ciox Health

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| Invoice #:  |        |
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# Please return stub with payment.

Please include invoice number on check.

#### PREPAYMENT REQUIRED

MRO 1000 Madison Avenue, Suite 100 Norristown, PA 19403

## Invoice 23156410 August 23, 2018



Phone: (610) 994-7500 Opt. 1 Fax: (610) 962-8421

Izamar Espinoza Lowrance, Lundell & Lofgren, P.C. 1218 S Jordan Parkway Suite B South Jordan, UT 84095

On 8/13/2018 the following healthcare provider received your request for copies of medical records:

## Jordan Valley Medical Center-West Valley Campus

3460 South Pioneer Parkway West Valley City, UT 84120

You requested records for:

This is your invoice for providing the copies of the medical records.

Your Reference ID:

MRO Request ID: 23156410

MRO Online Tracking Number: IAHCBGWR436DW

You can track and pay for your request online at:

www.roilog.com

Records consisting of more than 75 pages may be sent on CD-ROM.

Cancelled requests or unpaid invoices may be subject to a cancellation fee.

## **Fees**

| Search and Retrieval Fee: | \$21.16   |
|---------------------------|-----------|
| Number of Pages:          | 2170      |
| Tier 1:                   | \$21.20   |
| Tier 2:                   | \$681.60  |
| Tier 3:                   | \$0.00    |
| Media pages/materials:    | 0         |
| Media Fee:                | \$0.00    |
| Certification Fee:        | \$0.00    |
| Adjustments:              | \$0.00    |
| Postage:                  | \$31.84   |
| Sales Tax:                | \$48.14   |
| TOTAL:                    | \$803.94  |
| Paid at Facility:         | ( \$0.00) |
| Paid to MRO:              | (\$0.00)  |
| BALANCE DUE:              | \$803.94  |
|                           |           |

You may pay this invoice online at:

## **PAYMENT**

## www.roilog.com

You can send a check to:

MRO

P.O. Box 6410,

Southeastern, PA 19398-6410

MRO Tax ID (EIN): 01-0661910

Please write the Invoice # on the check or return this invoice with the payment.

By paying this invoice, you are representing that you: have reviewed, understood, and approved the charges; have agreed to pay them; and have agreed to the following terms. Any dispute relating to the charges in this invoice must be presented before paying this invoice. Any dispute not so presented is waived. Presentation of a dispute must be made by telephone (610) 994-7500 Opt. 1. Upon presentation of a dispute, your payment of the invoice will be noted as made under protest pending resolution of the dispute presented. All disputes regarding the charges in this invoice, whether presented by you or by MRO, must be resolved by arbitration under the Federal Arbitration Act through one or more neutral arbitrators before the American Arbitration Association (AAA). Your dispute will be resolved by the arbitrators, and not by a judge or a jury. Class arbitrations are not permitted. Disputes must be brought only in the claimant's individual capacity and not as a representative or member of a class. An arbitrator may not consolidate your dispute with the dispute of anyone else nor preside over any form of class proceeding. Upon request by you at the time a dispute is presented, MRO will pay the AAA fee for arbitration of your dispute.

Please contact MRO at (610) 994-7500 Opt. 1 for any questions regarding this invoice. MRO is the medical copy request processor for: Jordan Valley Medical Center-West Valley Campus.

#### \* Health .O. Box 409740 Atlanta, Georgia 30384-9740 Fed Tax ID 58 - 2659941 1-800-367-1500

CIOX HEALTH INVOICE

Invoice #:

Date: Customer #: 01/17/2020

Ship to:

DEWSNUP KING OLSEN ET AL DEWSNUP KING OLSEN ET AL 36 S STATE ST STE 2400 SALT LAKE CITY,UT 84111-1800 Bill to:

DEWSNUP KING OLSEN ET AL DEWSNUP KING OLSEN ET AL 36 S STATE ST STE 2400 SALT LAKE CITY,UT 84111-1800 Records from:

INTERMOUNTAIN HEALTHCARE 4646 W LAKE PARK BLVD WEST VALLEY CITY,UT 84120-8212

Requested By: Patient Name:

DEWSNUP KING OLSEN ET AL

DOB:

Your request for copies of medical records has been processed. Full payment in advance is required and must be received within 30 days of the receipt of this invoice, before your copies will be released. Promptly return the bottom portion of this invoice along with a check for the balance due. To expedite the request or to pay by credit card, please call 800-367-1500.

FULL PAYMENT REQUIRED PRIOR TO RELEASE OF RECORDS

| Description                     | Quantity   | Unit Price   | Amount |
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| Basic Fee                       |            | A COLUMN TO THE PERSON OF THE  | 21.61  |
| Retrieval Fee                   | * 4        |  | 0.00   |
| Per Page Copy (Elect) 2         | 40         | 0.27   | 10.80  |
| Per Page Copy (Elect) 1         | 5134       | 0.17   |        |
| Electronic Data Archive Fee     | 3234       | 0.17   | 872.78 |
| Subtotal                        |            |  | 2.00   |
| Sales Tax                       |            |  | 907.19 |
| Invoice Total                   |            |  | 70.31  |
| Balance Due                     |            |  | 977.50 |
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Ciox Health

P.O. Box 409740 Atlanta, Georgia 30384-9740 Fed Tax ID 58 - 2659941 1-800-367-1500

Get future medical records as soon as they are processed, by signing up for secure electronic delivery. Register at: https://edelivery.cioxhealth.com

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# Please return stub with payment.

Please include invoice number on check,

P.O. Box 409740 Atlanta, Georgia 30384-9740 Fed Tax ID 58 - 2659941 1-800-367-1500

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Ship to:

DEWSNUP KING OLSEN ET AL DEWSNUP KING OLSEN ET AL 36 S STATE ST STE 2400 SALT LAKE CITY,UT 84111-1800 Bill to:

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INTERMOUNTAIN HEALTHCARE 4646 W LAKE PARK BLVD WEST VALLEY CITY,UT 84120-8212

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DOB:

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| Description                 | Quantity            | Unit Price | Amount   |
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| Retrieval Fee               |                     |            | 21.61    |
| Per Page Copy (Elect) 2     | 40                  | 0.27       | 0.00     |
| Per Page Copy (Elect) 1     | 6038                | 0.27       | 10.80    |
| Electronic Data Archive Fee | 0038                | 0.17       | 1,026.46 |
| Subtotal                    |                     |            | 2.00     |
| Sales Tax                   |                     | İ          | 1,060.87 |
| Invoice Total               | i I                 |            | 82,22    |
| Balance Due                 |                     |            | 1,143.09 |
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### Ciox Health

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INTERMOUNTAIN HEALTHCARE 4646 W LAKE PARK BLVD WEST VALLEY CITY,UT 84120-8212

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### Ciox Health

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Get future medical records as soon as they are processed, by signing up for secure electronic delivery. Register at: https://edelivery.cioxhealth.com

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Bill to:

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Requested By: Patient Name:

DEWSNUP KING OLSEN ET AL

DOB:

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| Description                 | Quantity                   | Unit Price   | Amount   |
|-----------------------------|----------------------------|--|----------|
| Basic Fee                   | - 11                       |  | 21.61    |
| Retrieval Fee               |                            |  | 0.00     |
| Per Page Copy (Elect) 1     | . 7673                     | 0.17   | 1,304.41 |
| Per Page Copy (Elect) 2     | 40                         | 0.27   | 10.80    |
| Electronic Data Archive Fee |                            |  | 2.00     |
| Subtotal                    |                            |  | 1,338.82 |
| Sales Tax                   |                            |  | 103.76   |
| Invoice Total               |                            |  | 1,442.58 |
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#### Ciox Health

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Get future medical records as soon as they are processed, by signing up for secure electronic delivery. Register at: https://edelivery.cioxhealth.com

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# CIOX INVOICE

Invoice #:

Date: Customer #:



Ship to:

LOWRANCE LUNDELL LOFGREN LOWRANCE LUNDELL LOFGREN 1099 W SOUTH JORDAN PKWY SOUTH JORDAN,UT 84095-8809 Bill to:

LOWRANCE LUNDELL LOFGREN LOWRANCE LUNDELL LOFGREN 1099 W SOUTH JORDAN PKWY SOUTH JORDAN, UT 84095-8809 Records from:

INTERMOUNTAIN HEALTHCARE 1136 S 3600 WEST SUITE 100 SALT LAKE CITY,UT 84104

# RECEIVED

Requested By: Patient Name: LOWRANCE LUNDELL LOFGREN

LOWRANCE LONDELL LOYG

JUL 0 3 2019

Per your request, please let this serve as your fee approval notice for medical records requested from the facility listed above. If you would like to approve this amount please contact a Clox Health representative at 800-367-1500. If you would like to expedite delivery of your request, please go to https://paycioxhealth.com/pay/ to pay electronically.

| Description  | Quantity                      | Unit Price   | Amount                                      |
|--|-------------------------------|--------------|---|
| Basic Fee<br>Retrieval Fee<br>Per Page Copy (Paper) 1<br>Per Page Copy (Paper) 2<br>Shipping | 4095<br>40                    | 0.33<br>0.54 | 21.61<br>0.00<br>1,351.35<br>21.60<br>96.48 |
| Certification Fee<br>Subtotal<br>Sales Tax<br>Invoice Total                                  |                               |              | 10,00<br>1,501.04<br>101.11<br>1,602.15     |
| Balance Due  |                               |              | 1,602.15                                    |
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| Please remit   | this amount : \$1,602,15(USD) | >            |   |

Ciox Health

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Get future medical records as soon as they are processed, by signing up for secure electronic delivery. Register at: https://edelivery.cioxhealth.com

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| Payment Amount \$ |  |

# Please return stub with payment.

Please include invoice number on check.

To pay invoice online, please go to https://paycioxhealth.com/pay/ or call 800-367-1500. Email questions to collections@cioxhealth.com.

CHARA / AAS

### x Health

2.0. Box 409740 Atlanta, Georgia 30384-9740 Fed Tax ID 58 - 2659941 1-800-367-1500



Invoice #:

Date: Customer #: 10/20/2020

Ship to:

DEWSNUP KING OLSEN ET AL DEWSNUP KING OLSEN ET AL 36 S STATE ST STÉ 2400 SALT LAKE CITY,UT 84111-1800 Bill to:

DEWSNUP KING OLSEN ET AL DEWSNUP KING OLSEN ET AL 36 S STATE ST STE 2400 SALT LAKE CITY,UT 84111-1800 Records from:

YUMA REGIONAL MEDICAL CENTER 2400 S AVENUE A YUMA,AZ 85364-7127

Requested By:

DEWSNUP KING OLSEN ET AL

DOB:

Patient Name:

Your request for copies of medical records has been processed. Full payment in advance is required and must be received within 30 days of the receipt of this invoice, before your copies will be released. Promptly return the bottom portion of this invoice along with a check for the balance due. To expedite the request or to pay by credit card, please call 800-367-1500.

FULL PAYMENT REQUIRED PRIOR TO RELEASE OF RECORDS

| Description                 | Quantity | Unit Price | Amount   |
|-----------------------------|----------|------------|----------|
| Basic Fee                   |          |            | 20,00    |
| Retrieval Fee               |          |            | 0.00     |
| Per Page Copy (Paper) 1     | 3405     | 0.60       | 2,043.00 |
| Per Page Copy (Paper) 2     | 50       | 0.80       | 40.00    |
| Per Page Copy (Paper) 3     | 50       | 1.10       | 55.00    |
| Electronic Data Archive Fee |          |            | 2.00     |
| Subtotal                    |          |            | 2,160,00 |
| Sales Tax                   |          |            | 167.40   |
| Invoice Total               |          |            | 2,327.40 |
| Balance Due                 |          |            | 2,327.40 |
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|                             |          |            |          |

Please remit this amount : \$2,327.40(USD)

#### Ciox Health

P.O. Box 409740 Atlanta, Georgia 30384-9740 Fed Tax ID 58 - 2659941 1-800-367-1500

Get future medical records as soon as they are processed, by signing up for secure electronic delivery. Register at: https://edelivery.cioxhealth.com

| Invoice #: |  |  |  |
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| Payment Ar | mount \$   |  |  |

# Please return stub with payment.

Please include invoice number on check.

P.O. Box 409740 Atlanta, Georgia 30384-9740 Fed Tax ID 58 - 2659941 1-800-367-1500

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| Invoice #: |  |
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| Date:      | 10/14/2020   |
| Customer # | Commence of the Commence of th |

Ship to:

Amanda Corey REICHERT ARMSTRONG ATTYS AT LA 118 BELMONT RD GRAND FORKS,ND 58201-4651 Bill to:

Amanda Corey REICHERT ARMSTRONG ATTYS AT LA 118 BELMONT RD GRAND FORKS,ND 58201-4651 Records from:

GILLETTE CHILDRENS SPECIALTY 200 UNIVERSITY AVE E SAINT PAUL,MN 55101-2507

Requested By:

REICHERT ARMSTRONG ATTYS AT LA

DOB:



Patient Name:

Per your request, please let this serve as your fee approval notice for medical records requested from the facility listed above. If you would like to approve this amount please contact a Ciox Health representative at 800-367-1500. If you would like to pay electronically, please go to https://paycioxhealth.com/pay/.

| Description                 | Quantity              | Unit Price | Amount    |
|-----------------------------|-----------------------|------------|-----------|
| Basic Fee                   |                       |            | 19.19     |
| Retrieval Fee               |                       |            | 0.00      |
| Per Page Copy (Paper) 1     | 10224                 | 1.44       | 14,722.56 |
| Electronic Data Archive Fee |                       |            | 2.00      |
| Subtotal                    |                       |            | 14,743.75 |
| Sales Tax                   |                       |            | 0.00      |
| Invoice Total               |                       |            | 14,743.75 |
| Balance Due                 |                       |            | 14,743.75 |
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|                             |                       |            |           |
| Please remit this amou      | nt : \$14,743.75(USD) |            |           |

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Get future medical records as soon as they are processed, by signing up for secure electronic delivery. Register at: https://edelivery.cioxhealth.com

| Invoice #:         | 3 |
|--------------------|---|
| Check #            |   |
| Payment Amount \$_ | - |

## Please return stub with payment.

Please include invoice number on check.