

HEALTH **X** SOURCE

Registered Members

Email:

Password:

[Forgot Password?](#)

Log In

Sign Up

OR

Guest No Log In or Enrollment is required.

First Name:

Last Name:

DOB:

Last 4 of SSN:

Continue as Guest

Ciox HealthSource is a fully scalable clinical data platform

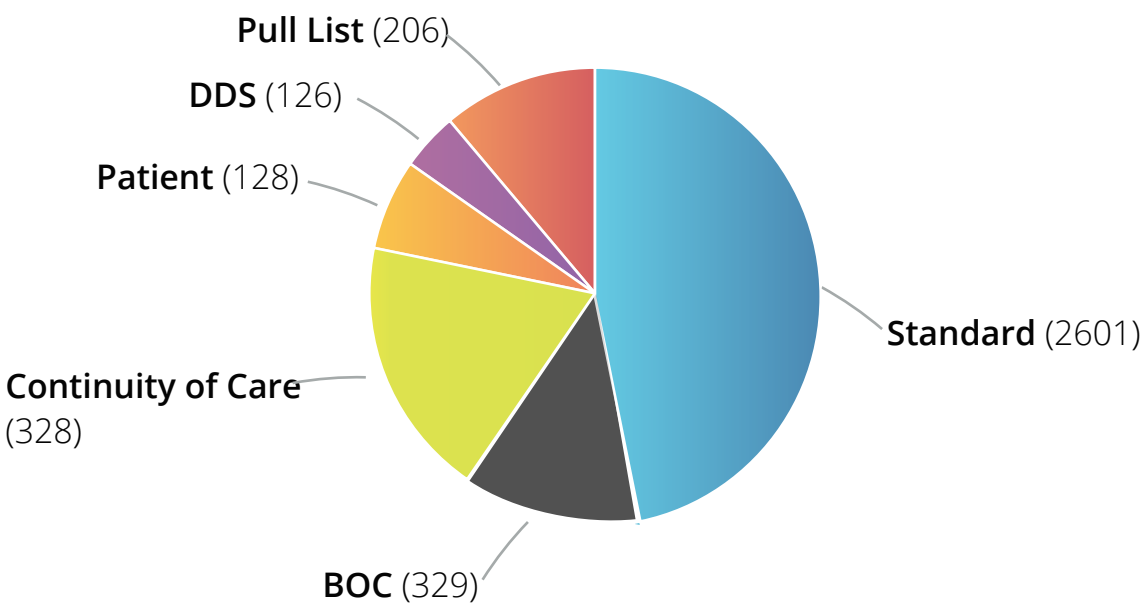
Ciox HealthSource is a secure, cloud-based information sharing platform that transforms the way healthcare information is shared and acted upon – resulting in a better quality of life and improved healthcare outcomes across the US.

Display by Status: ☒ Logging ☐ Fulfillment

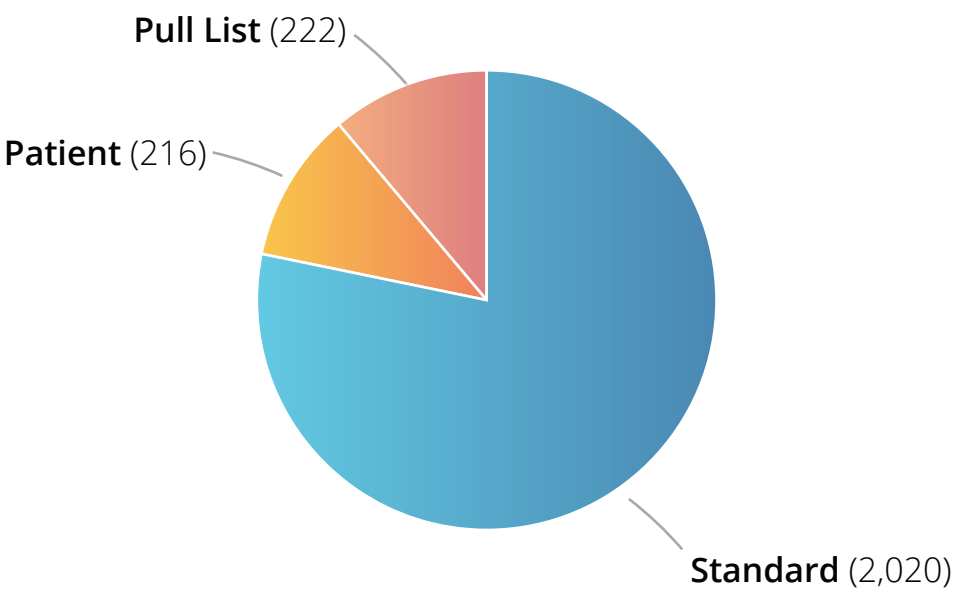
Select by Site(s):

[+ Add Request](#)

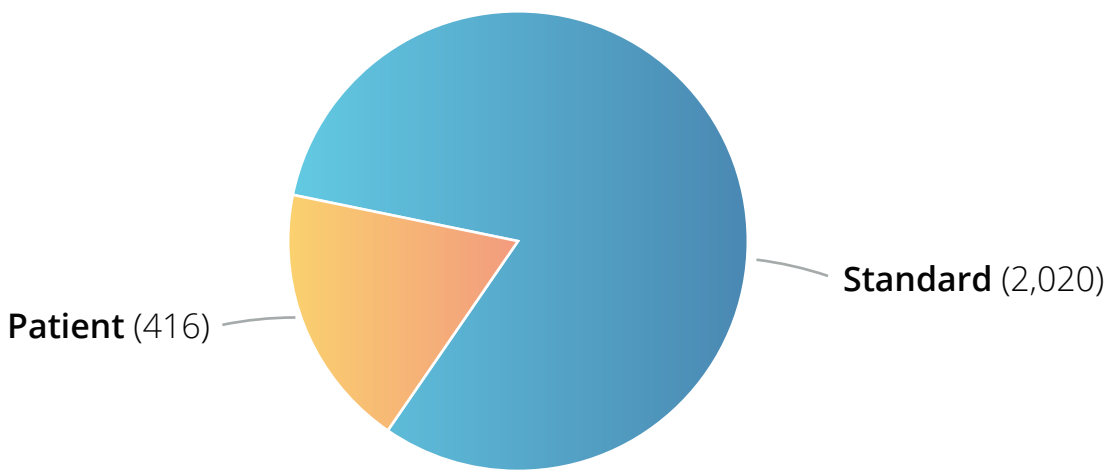
Ready to Work



Holds



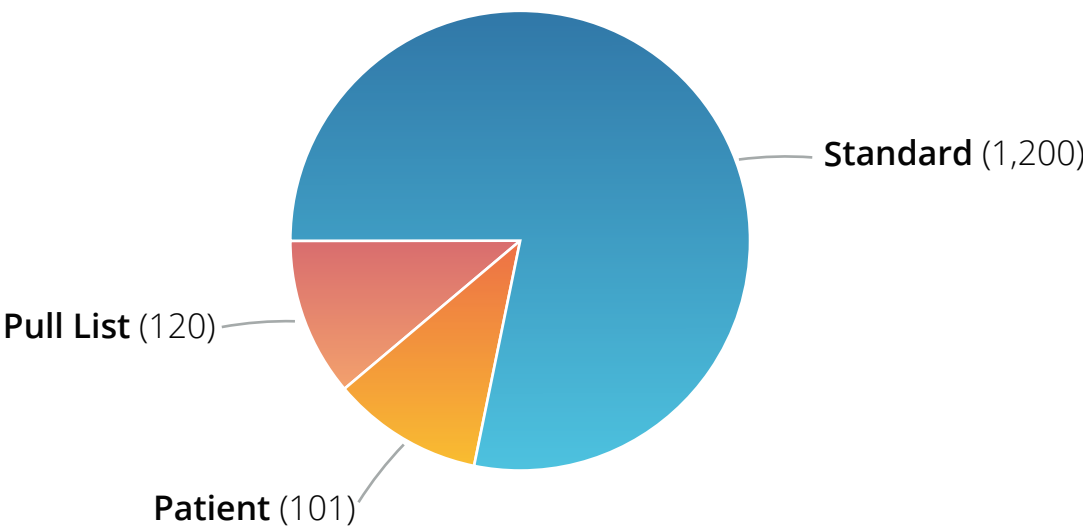
Exceptions



My Statistics

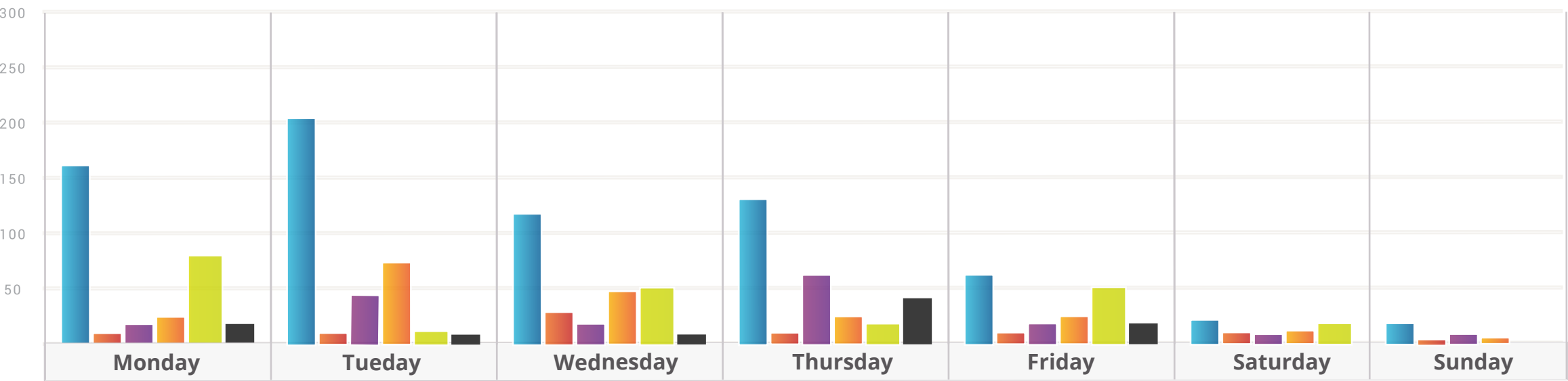
Request Breakdown

From 01/01/2019 - To 02/01/2019



Request Breakdown

From 02/04/2019 - To 02/10/2019



Navigation icons: zoom in/out, fit width, print, settings, etc.

Notifications (8), Bookmarks, Flags, and other utility icons

Progress bar with steps: Patient (active), Requester, Payment

Patient Information

Form fields for Patient Information: First Name, Last Name, DOB, MRN, SSN, MBI, Claim #, Dates of Service(s).

Medical Record Types

Checkbox: All Record Types

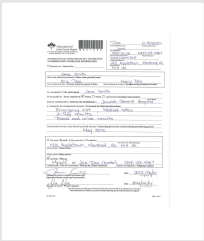
Reports: ⓘ

Drag & Drop Request Letter or select an option below. Includes Attach and Scan buttons.

Maximum Upload File Size: 5 MG



Request Letter



1

Hôpital général juif / Jewish General Hospital
3755, Côte-Ste-Catherine, Montréal, QC H3T 1E2
Archives Médicales Tél : (514) 340-8202

AUTORISATION DE COMMUNIQUER DE L'INFORMATION / AUTHORIZATION TO RELEASE INFORMATION

☐ Répondue par / Answered by : _____

Handwritten Form Data:

- Family Name: Doe, Record No: U-5000001
- First Name: Jane, Date of Birth: 1900-01-31, Telephone: (514) 123-4567
- Birth Number: DOEJ00513110
- Address: 123 Appletown, Montreal, Qc, HIH 1A1
- Other Name Presently Used: Jane Smith
- Father's Name: Eric Doe, Mother's Name: Mary Doe
- Signature: Jane Smith, Capacity: Patient
- Authorized Establishment: Jewish General Hospital
- Information to Transmit: Emergency visit, Medical notes, X-Ray results, Blood and urine results
- Services Received: May 2012
- Mailing Address: 123 Appletown, Montreal, Qc HIH 1A1
- Pick-up by: Myself or Joe Doe (brother), Telephone: (514) 123-4567
- Signatures: Jane Smith (Patient), Joe Doe (Witness), Date: 2012/06/01

Cette autorisation est valide pour une période de 90 jours suivant la date de la signature de ce document. / This authorization is valid for a period of 90 days following the date this document was signed.

Patient

Requester

Payment

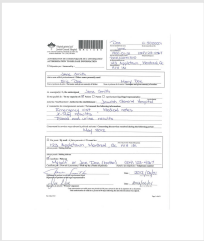


Medical Record Types

- ☐ All Record Types
- Reports:** ⓘ
- ☐ Cardiology W/EKG Report
 - ☐ Emergency Room Report
 - ☐ History / Physical Report
 - ☐ Immunization Report
 - ☐ Laboratory Report
 - ☐ Operative / Procedure Report
 - ☐ Pathology Report
 - ☐ Physician Orders Report
 - ☐ Radiology Report
- Notes:** ⓘ
- ☐ Consultation
 - ☐ Nurse Notes
 - ☐ Progress Notes
 - ☐ Therapy Notes
- Summaries** ⓘ
- ☐ Abstract Summary
 - ☐ Admission Sheet
 - ☐ Continuity Care Document
 - ☐ Discharge Summary
 - ☐ Itemized Billing Statements



Request Letter



1

Hôpital général juif / Jewish General Hospital
3755, Côte-Ste-Catherine, Montréal, QC H3T 1E2
Archives Médicales Tél : (514) 340-8202

AUTORISATION DE COMMUNIQUER DE L'INFORMATION / AUTHORIZATION TO RELEASE INFORMATION

☐ Répondue par / Answered by : _____

Docteur / Doctor: Jane Smith
Autre nom utilisé présentement / Other name presently used: Eric Doe
Nom et prénom du père / Surname and given name(s) of father: Mary Doe
Nom et prénom de la mère / Surname and given name(s) of mother: Mary Doe

Je, soussigné(e) / I, the undersigned: Jane Smith
En ma qualité de: / In my capacity of: ☒ Patient ☐ Parent ☐ représentant légal/legal representative

Autorise l'établissement / Authorize the establishment: Jewish General Hospital

À transmettre les renseignements suivants / To transmit the following information:
Emergency visit, Medical notes, X-Ray results, Blood and urine results

Concernant les services reçus durant la période suivante / Concerning the services received during the following period: May 2012

☐ Par poste / By mail : À faire parvenir à / To send to : 123 Appletown, Montreal, QC H1H 1A1
Adresse postale / Mailing Address: 123 Appletown, Montreal, QC H1H 1A1

☒ Cueillette / Pick-up
Cueillette par: (Nom de la personne) / Pick-up by: (Name of person): Myself or Joe Doe (brother)
Numéro de téléphone / Telephone number: (514) 123-4567

Signature du patient ou de son représentant légal / Signature of patient or his legal representative: Jane Smith
Date: 2012/06/01

Signature du témoin / Witness' signature: Joe Doe
Date: 2012/06/01

Cette autorisation est valide pour une période de 90 jours suivant la date de la signature de ce document.
This authorization is valid for a period of 90 days following the date this document was signed.

Patient

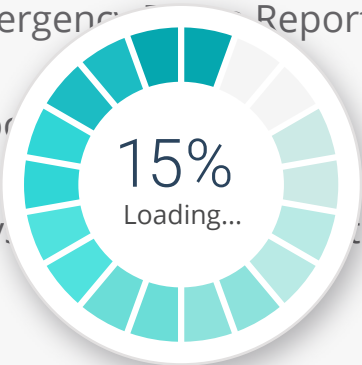
Requester

Payment



Medical Record Types

- ☐ All Record Types
- Reports:** ⓘ
 - ☒ Cardiology W/EKG Report
 - ☒ Immunization Report
 - ☐ Pathology Report
 - ☐ Emergency Report
 - ☐ Laboratory Report
 - ☐ Physical Exam Report
 - ☐ History / Physical Report
 - ☐ Operative / Procedure Report
 - ☐ Radiology Report
- Notes:** ⓘ
 - ☐ Consultation
 - ☐ Therapy Notes
 - ☐ Nurse Notes
 - ☐ Progress Notes
- Summaries** ⓘ
 - ☐ Abstract Summary
 - ☐ Discharge Summary
 - ☐ Admission Sheet
 - ☐ Itemized Billing Statements
 - ☐ Continuity Care Document



Previous

Continue

 U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF INVESTIGATION 475 L'Enfant Plaza, N.W. Washington, D.C. 20045-4501		File No. <u>100-368691</u> Date Rec'd. <u>10/26/94</u> Agent <u>W. J. B. / J. J. B.</u> Title <u>RECEIVED</u> Date <u>10/26/94</u> By <u>W. J. B. / J. J. B.</u>
		File No. <u>100-368691</u> Date Rec'd. <u>10/26/94</u> Agent <u>W. J. B. / J. J. B.</u> Title <u>RECEIVED</u> Date <u>10/26/94</u> By <u>W. J. B. / J. J. B.</u>
Title <u>_____</u> Date <u>_____</u> By <u>_____</u>		
File No. <u>100-368691</u> Date Rec'd. <u>10/26/94</u> Agent <u>W. J. B. / J. J. B.</u>		
I hereby certify that the above is a true and correct copy of the original document.		
Special Agent in Charge <u>_____</u>		
Date <u>10/26/94</u>		
Title <u>Special Agent in Charge</u>		
Name <u>_____</u>		
Address <u>_____</u>		
City <u>_____</u>		
State <u>_____</u>		
Zip <u>_____</u>		
Phone <u>_____</u>		
Fax <u>_____</u>		
E-mail <u>_____</u>		
Signature <u>_____</u>		
Date <u>10/26/94</u>		
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Fax <u>_____</u>		
E-mail <u>_____</u>		
Signature <u>_____</u>		
Date <u>10/26/94</u>		
Title <u>Special Agent in Charge</u>		

1

Rev May 2012

Page 1 of 1

Payment



Address 2:

Zip: *

- Select Option -

Email:

Request Letter Date: * ⓘ

- Select Option -

mm/dd/yyyy 

mm/dd/yyyy

Comments:

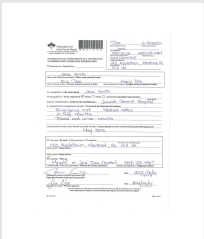
mm/dd/yyyy

[◀ Previous](#)

Continue ➤



Request Letter



1

Hôpital général juif / Jewish General Hospital

3755, Côte-Ste-Catherine, Montréal, QC H3T 1E2

Archives Médicales Tél : (514) 340-8202

AUTORISATION DE COMMUNIQUER DE L'INFORMATION / AUTHORIZATION TO RELEASE INFORMATION

☐ Répondue par / Answered by :

Jane Smith
Autre nom utilisé présentement / Other name presently used

Eric Doe Mary Doe
Nom et prénom du père / Surname and given name(s) of father Nom et prénom de la mère / Surname and given name(s) of mother

Je, soussigné(e) / I, the undersigned Jane Smith

En ma qualité de: / In my capacity of: ☒ Patient ☐ Parent ☐ représentant légal/legal representative

Autorise l'établissement / Authorize the establishment : Jewish General Hospital

À transmettre les renseignements suivants / To transmit the following information:

Emergency visit, Medical notes
X-Ray results
Blood and urine results

Concernant les services reçus durant la période suivante / Concerning the services received during the following period:

May 2012

☐ Par poste / By mail : À faire parvenir à / To send to : 123 Appletown, Montreal, QC H1H 1A1

Adresse postale / Mailing Address

☒ Cueillette / Pick-up

Myself or Joe Doe (brother) (514) 123-4567
Cueillette par: (Nom de la personne) / Pick-up by: (Name of person) Numéro de téléphone / Telephone number

Jane Smith
Signature du patient ou de son représentant légal / Signature of patient or his legal representative

Joe Doe
Signature du témoin / Witness' signature

Date : 2012/06/01
Date : 2012/06/01

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Rev May 2012 Page 1 de/ of 1

Patient

Requester

Payment

Payment

Delivery Options:

- ☒ Secure Electronic (\$25.00)
- ☐ Mail to Fedex (\$25.00)
- ☐ Facility Pickup (Free)

Payment Options:

- ☒ Credit Card
- ☐ Bill me later



Name on Card: *

Card Number: *

Expiration Date: *

MM

YY

Security code: * ⓘ

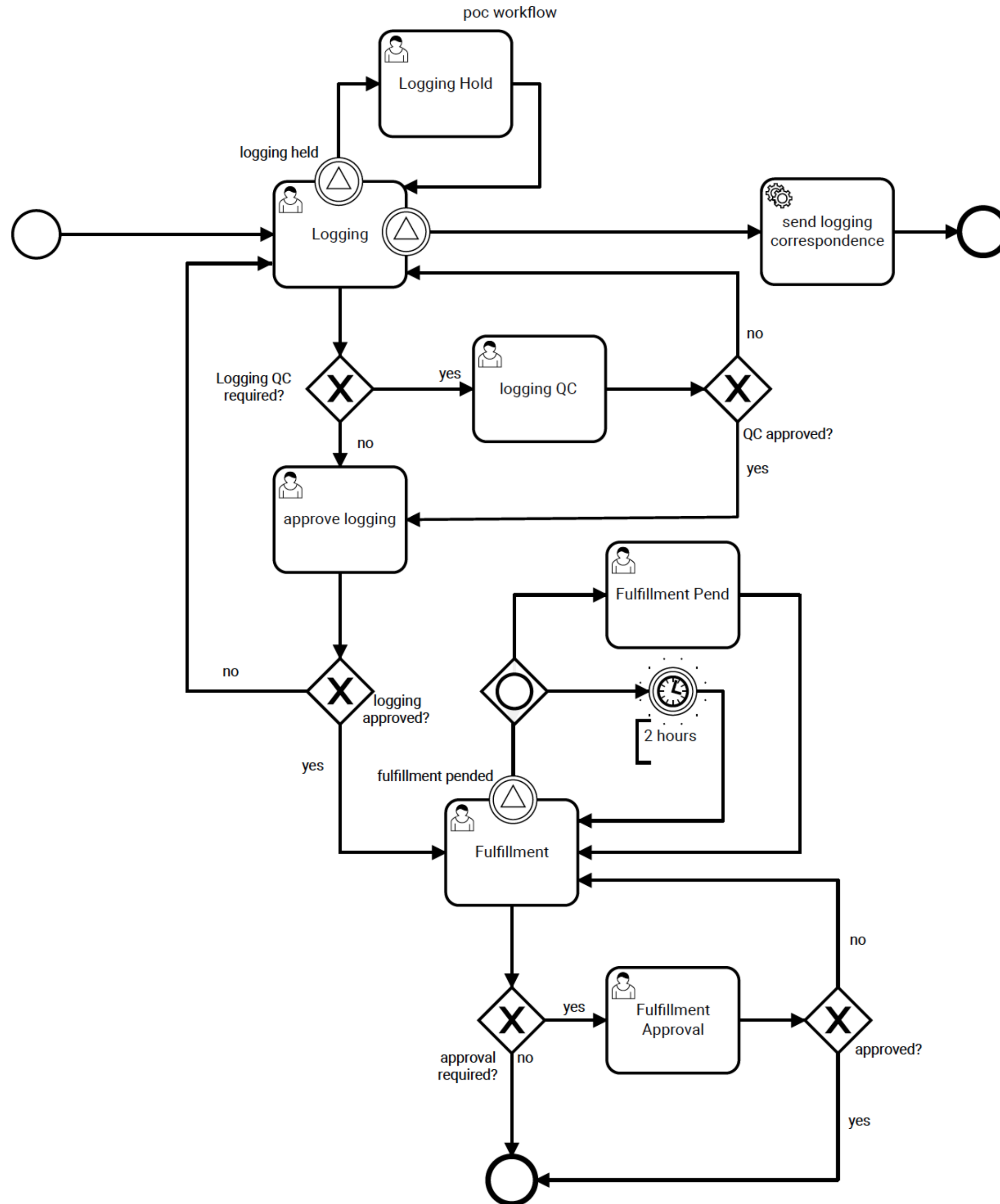
Order Summary

Tax	Page(s)	Amount
Request Letter	1	\$0.00
Medical Records	50	\$25.00
Tax		\$1.75
Order Total		\$26.75

Previous

Submit

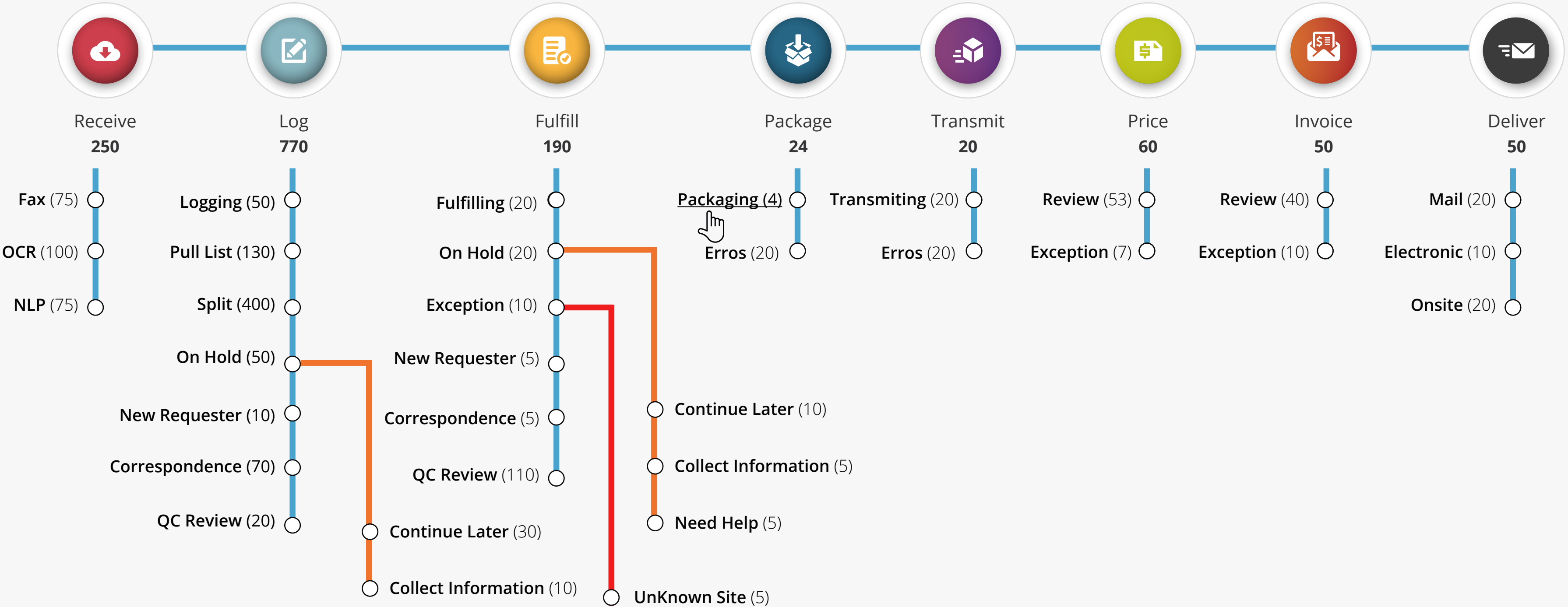
Application Workflow Diagram



Request Tracking

Site ID

Search by Site ID



Filter Results

Patient Last Name:

Patient First Name:

Patient DOB:

mm/dd/yyyy

eRequest ID:

Requester Name:

Date Range:

FromTo

Clear Filter

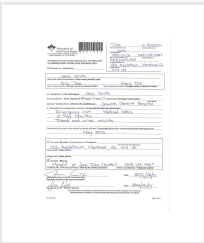
◀ Back to Request Tracking

Request(s)

eRequest ID	Requester	Patient	Request Received Date ▾		Status
23886840	Jane Smith	Jane Smith	08/28/2018	03:00 pm	Packaged
00086822	Emily Madison	Mason Smith	08/28/2018	09:52 am	Packaged
11186811	Matthew Alexander	Andrew Jordan	08/27/2018	10:52 am	Packaged
99986855	Benjamin Williams	Gavin Jones	08/27/2018	05:52 am	Packaged



Medical Records



1

03/19/2007 13:46 7135206644 WILLIAM B CONNOLLY PAGE 47/99

MILLCREST
Millcrest Baptist Medical Center

000052886074 MR 000556762
JACKSON, MARQUIET
M 12 B 12/06/03 OER
E.R. PHYS:

Emergency Department Nursing Record

PMH: Birth weight: kg/lb Hospitalizations: None
Shots: Current Unknown Not current: DPT Hib Hep B OPV MMR Varicella
Medical: Prematurity FIT Asthma DM Recurrent UTI's Recurrent otitis
Esophageal reflux Cancer
Operations / Other: None

Medications: None See attached list Unknown

Allergies: None latex

CC: LACERATION, CHIN

TRIAGE:
Source: Patient Family Friend Guardian Nursing home Paramedic Police Interpreter
Mode of arrival: Walk in Wheelchair Friends Attendant Ambulance Helicopter Police
Location: R L Middle Chin Lip
Timing: Occurred 3 Minutes Hours Days ago
Context: Mechanism: MVA Work related Sporting Allegation Fall Unknown
Caused by: Glass Knife Metal Wood Blunt trauma fall
Last tetanus: UTD > 5 years Unknown

Other history:
new contact
bleeding @ the time
bandaid over chin
Richardson

Signature: [Signature]

NURSING ASSESSMENT: Room: ELK 12 7:53 am pm
Nursing history: ☒ Triage assessment reviewed
Source: Patient Family Friend Guardian Nursing home Paramedic Police Interpreter
Prehospital: CPR Intubation O2 IV C-collar Backboard Splints Meds None
Associated signs and symptoms: None
Loss of consciousness Jaw pain Abnormal bite Tooth injury
Other history:
A ~ 1830 - was being restrained
to hit chin on concrete - status
to the west chin about 1/2 lig - down
low

Nursing exam:
Constitutional: Alert Cooperative Well-appearing Ill-appearing ETOH Normal
Respiratory: R L Bil Wheezes Rales Rhonchi Normal
CV: Tachycardia Bradycardia Irregular Normal
Neurologic: Oriented to: Time Person Place Not oriented Unable to test Normal
Motor function: R L Arm Leg Face Weak Unable to test Normal
Skin: Chin laceration cm
Other exam:
1/2" lacer below lower lip -
minimal bleeding noted

NURSING DIAGNOSIS: Impaired skin integrity Altered comfort: Pain Potential infection
NURSING PLAN: To appropriate area Cleanse Dressing applied
EXPECTED OUTCOME: Integrity maintained Pain control/Absent Infection control/Absent

LVN [Signature] RN

Other Assessments
Head circumference: 48
Developmental age appropriate? YES NO If no, explain:
Evidence of abuse/neglect? YES NO If yes, person notified:
Discharge planning
Special educational needs of patient/family? YES NO Explain:
Patient/Family readiness to learn? Good Fair Poor

Orders, Interventions, and Results
Standing orders or initial interventions
☐ Pw MD notified: YES NO
☐ Accastreak
☐ O2:
☐ IV:
☐ Monitor
☐ XR:
☐ Labs:
☐ Urine dip Micro sent: Y N
☐ Urine pregnancy test
☐ Breathing treatments
☐ Splint(s)
☐ Dressing (s)
☐ Tetanus (see medication section)



Patient Information

First Name: *

Last Name: *

DOB:

MRN: ⓘ

SSN:

MBI: ⓘ

Claim #: ⓘ

Dates of Service(s):



Medical Record Types



Requester Information



Payment Information

Back to Results



USER PERSONA

Susan Williams

ABOUT

	Job Title:	Manager
	Industry:	Healthcare
	Reports to:	Director of Operations
	Age:	42
	Computer Skills:	Expert

TYPICAL DAY

A typical day in the life of your persona: Meetings, conference calls, reviewing productivity, deadlines, budgets, implementations, security/privacy procedures – Risk assessments, TJC compliance, CMS compliance, reviewing workflows for process improvements, dealing with staffing issues, dealing with patient complaints. A bad day; lots of complaints, records have many mixed accounts from system downtime problems or imaging problems, charts not available for clinicians to provide quality care.

TYPICAL INTERACTION WITH OUR PRODUCT

Audit: Looking to review the outstanding Audits, the information that is being requested, the outcomes of the audits – success vs. fails, what has been the biggest challenge in the audit process.

A PERFECT WORK DAY

No missed deadlines, everyone is happy, no complaints from patients or employees, all audits were successful in recouping payment, all employees are productive, all charts coded accurately, no breaches in privacy or security, no downtime procedures were implemented.

Ciox Health Legacy Application



A screenshot of a legacy application login window titled "PRISM ROI Login". The window has a light gray background and a green title bar. In the top-left corner of the window is a small icon of a key. The text "PRISM[®] ROI" is displayed in a large, bold, black font. Below the logo, there are two input fields: "User Name" and "Password". The "User Name" field is a white rectangle with a thin black border. The "Password" field is a white rectangle with a thin black border. Below the input fields are two buttons: "OK" and "Cancel". The "OK" button is a gray rectangle with a black border. The "Cancel" button is a gray rectangle with a black border. Below the buttons is a blue hyperlink that reads "Forgot/Unlock Password".

PRISM[®] ROI

User Name

Password

OK Cancel

[Forgot/Unlock Password](#)

Orders			
Add	Add from EMR	Search	Search Repeat
Refresh	Update	Delete	History
Export Docs	Help	Close	

Record 1 of 1

View Queue History

REQUESTER INFORMATION

Requester Name: *

Customer ID:

See Notes

Search

Edit

Terms:

Repeat Last

Bill Address: *

City: *

State, ZIP Code: *

Country:

Ship Address: *

City: *

State, ZIP Code: *

Country:

Claim/File Number:

TDN/Payment ID:

Attention:

Charge Type: *

Pref. Delivery: *

Sent Via

Ship Contact

INVOICE INFORMATION

Invoice Generated:

Invoice No:

Invoice Paid:

Invoice Total:

Date Invoiced:

Amount Paid:

Date Paid:

Credits/Adjustments:

Check No:

Amount Due:

Preview

Remove

ORDER INFORMATION

Order No:

Order Date:

RQs:

Status: *

Reason:

Site: *

Rec Loc: *

Received:

Ready:

Due Date:

Clone Of:

Clone Order

View

Sent:

Provider:

Add/Edit Providers

PATIENT INFORMATION

Last Name: *

First Name: *

SSN:

MR No:

DOB:

Patient Acct.:

EMRN:

MBI:

Audit

Lock

Service Dates

Custom Fields

☐ Stat

☐ HITECH EMR Req

☐ HITECH DI-CS

COMPLETION INFORMATION

Copy Date:

Copied By:

Fee Limit:

Force is Write-Up

Pages:

Copy Notes:

PL Rest Wrng

Quote

Complete Order

Print Invoice

Undo Invoice

Mark Un-delivered

Review Auth

Review Docs

Delivery MR Using

Print

esMD

SSA

Fax

DPM

Direct

SFTP

PP

Customer Relations

Print Backup

Smarmklink Application

SmartLink® - Login

SmartLink® 5.1.1.0

User Name

Password

Site #

Reset Password

Log In

Cancel

www.healthport.com

SmartLink - Confirm Site

You have entered site # 28481
FAWCETT MEMORIAL HOSPITAL
21298 OLEAN BOULEVARD
PORT CHARLOTTE, FL 33952

Please confirm your site selection. Do this by entering the first 5 characters of the site name (without spaces) and the 2-letter state code for the site's state.

First 5 here:

State here:

Continue

Cancel

SmartLink® - Version: 5.1.1 - User: MICHELA LOUIS (822026) - Site: FAWCETT MEMORIAL HOSPITAL (28481)

FileToolsLogHelp

Job InformationRequest LetterMedical RecordPackage JobTransmit

Request #

Field Request11UVSZQS0000040

eSmartLog ID#219450831

MRN

Billing Information

Billable Request

Fee Approval Required

Non Billable Request

Correspondence

Site Information

Site #28481

NameFAWCETT MEMORIAL HOSPITAL

Address 121298 OLEAN BOULEVARD

Address 2

CityPORT CHARLOTTE

StateFL

Zip Code33952

Requester Information

NameDcf

Address1317 Winewood Blvd

Bldg 1 Rm 2

Tallahassee, FL 32399

Special Processing

On-Site Copy Job

This is an On-Site Pick Up

Paper Pages0

Microfilm Pages0

Electronic Pages0

Special Project

Return Records to Facility

HealthPort Connect BOC Request

Customer Requested Electronic Delivery

Years Searched1

Payment Information

Check/Money Order Received with Request

Requester Deposit

Facility Kept Payment

Check Date9/17/2019

Check

Amount0Dollar0Cents

Patient Information

NameWilliam Niece

DOB10/13/1967

Medical Rec #F000316437

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08/22/19

DRK

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Date Entered:08/22/19

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Site Number:25167

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Requester Information

NameDcf

Address1317 Winewood Blvd

Bldg 1 Rm 2

Tallahassee, FL 32399

Patient Information

NameWilliam Niece

DOB10/13/1967

Medical Rec #F000316437

Help

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