UNIVERSITY OF CHICAGO ORGANIZED HEALTH CARE ARRANGEMENT REQUEST AND AUTHORIZATION TO COPY HEALTH INFORMATION

THE UNIVERSITY OF CHICAGO MEDICINE

For the purposes of release of health information, records are available at the following University of Chicago Organizations: The University of Chicago Medical Center, The UC Pediatric Specialty Clinics, The University of Chicago Physicians Group, and UCMC Community Physicians, LLC

How do I request a copy of my health information (Includes medical records, bills and x-ray films)?

You can request a copy of your health information by completing a Request and Authorization form and submitting it to the UC Organization which maintains your health information, as stated above.

You can submit this form to the appropriate UC Organization by mail or in person (see reverse side for addresses). If you are submitting your request in person at the University of Chicago Medicine, you may do so from 8:30 a.m. to 4:00 p.m. at one of the following locations:

- The Medical Records Department in WB-20 of the Billings building
- Outpatient Registration 1st Floor – Duchossois Center For Advanced Medicine (DCAM)
- Outpatient Registration 2nd Floor – Duchossois Center For Advanced Medicine (DCAM)

If you are hospitalized, you may submit this form at the Admitting Office near the Mitchell Hospital lobby, when you are discharged from the hospital.

Who is authorized to sign for release of my health information?

- The following people are authorized to sign for release of your health information:
- The patient (Not the spouse)
- Power of attorney if the patient is unable to sign (Legal document must be provided.)
- Parent (If the patient is younger than age 18)
- Parent and minor if the patient is 12-17 years of age and receiving psychiatric, alcohol, or drug treatment services.
- Legal guardian (Proof of guardianship document must be provided.)
- Representative of the estate for deceased patients (Copy of the death certificate and a copy of the representative of estate documents must be provided).

How much does it cost to obtain a copy of my health information?

- There is no charge for processing copies of health information directly to other healthcare providers.
- Patients will be charged a fee for copies of their health information.
- To reduce the cost, patients should consider requesting specific information rather than a complete record.
- The fee for patients to access copies of their health information is postage plus the following

Number of Copies	Cost for Medical Records
Processing Fee	**See below for details ****
Page number 1-25	$1.00 per page
Additional charges apply for requests greater than 25 pages	
Page number 26-50	$.67 per page
Page number 51 and more	$.33 per page
Record on CD	50% of paper pricing
X-Rays on CD (multiple exams)	$10.00 per CD

**Pricing reflects the State of Illinois 2016 copying fees (735 ILCS)*

- Records will not be released until payment is received.
- ** When patients request copies for parties other than themselves and healthcare providers, the recipient of those copies will be charged a processing fee of $26.77. Send Payment for processing fee with the request.
- Copies made from Microfiche or Microfilm will be charged $1.67 per page regardless of the number of pages requested.

When will I receive a copy of my medical record?

Copies are processed within 15-30 days from the date the request is received by a UC Organization. Recipients will be notified if the request cannot be processed within that time frame.

Who do I contact if I have questions?

If you have any questions, please contact the UC Organization for maintaining your records (see reverse side for contact information).

Send your Request and Authorization to Copy Health Information to the UC Organization that maintains your records.

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ADDRESS LIST OF UC ORGANIZATIONS TO MAIL REQUESTS FOR COPIES OF HEALTH INFORMATION

UNIVERSITY OF CHICAGO MEDICINE

Medical Records	Billing Records	Radiology Films
University of Chicago Medicine Medical Records Dept. – MC 0978 5841 S. Maryland Ave. Chicago, IL 60637 Phone: 773-702-1637 Fax: 773-702-7591	University of Chicago Medicine Patient Accounts Dept. – MC 1068 8201 Cass Avenue Chicago, IL 60561 Phone: 773-702-6664 Fax: 773-702-8608	University of Chicago Medicine Radiology Dept. – MC 2026 Radiology Film Requests 5841 S. Maryland Ave. Chicago, IL 60637 Phone: 773-702-9662

UNIVERSITY OF CHICAGO PEDIATRIC SPECIALTY CLINICS

Medical Records	Medical Records	Billing Records
University of Chicago Pediatric Specialists 8528 Broadway Merrillville, IN 46410 Phone: 219-756-1200	University of Chicago Pediatric Specialists 7350 W. College Dr., Ste. 102 Palos Heights, IL 60463 Phone: 708-448-8000	University of Chicago Physicians Group 75 Remittance Drive, Ste. 1385 Chicago, IL 60675-1385 Phone: 773-702-1150 Fax: 773-702-0000

UNIVERSITY OF CHICAGO OFF-SITE CLINICS

Child Life Center 19550 Governors Highway, Ste. 2500 Flossmoor, IL 60422 Phone: 708-799-7600	University of Chicago Physicians at Matteson One Prairie Center 4749 Lincoln Mall Dr. Matteson, IL 60443 Phone: 708-748-2310	University of Chicago Obstetrics and Gynecology 1870 Silver Cross Boulevard New Lenox, IL 60451 Phone: 773-702-6642

UNIVERSITY OF CHICAGO PHYSICIANS GROUP—PHYSICIAN BILLING

UCPG
75 Remittance Drive, Suite 1385
Chicago, IL 60675-1385
Phone: 773-702-1150
Fax: 773-702-0000

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GUIDELINES FOR COMPLETING THE REQUEST AND AUTHORIZATION FORM

Please read the following guidelines for completing the Request and Authorization To Copy Health Information Form

SECTION I: Patient Information

In Section One, print the following information about the patient.

- Full name (first, last and middle initial)
- Birth date
- UC organization's Medical record number (if known)
- Full street address
- City, State, Zip
- Phone number

SECTION II: Information Requested

• To reduce your cost, you should consider requesting specific information rather than a complete record. In Section Two, select the category of information you specifically want copied. Documents will be copied for the dates of treatment you specify.

• Specify the date(s) of treatment or time frame for which you are requesting records (for example: specific date 1/25/03; range of dates Jan-July 2001; all dates of service).

• Select the UC organization responsible for maintaining your records. If you have been treated at more than one UC organization, check all that apply and your request will be forwarded to each location for processing.
NOTE: Copies of your records will be sent separately from each location.

SECTION III: Recipient and Purpose

• In Section three, print the name, phone number and address of the person you are authorizing to receive copies of your records.

• Describe the purpose for releasing the information.

SECTION IV: Specific Consent

If you are requesting any UC Organization to release information about a mental illness or developmental disability, HIV/AIDS testing or treatment, communicable diseases, sexually transmitted disease(s), substance (i.e., alcohol or drug) abuse, abuse of an adult with a disability, sexual assault, child abuse and neglect, or genetic testing, then in Section Four, you must check all categories of the specific information you want released.

SECTION V: Revocation of Authorization

In Section Five, specify the conditions under which the authorization will remain effective. The authorization will remain effective under the conditions you select unless you notify the Privacy Office in writing that you want to revoke the authorization.

SIGNATURE:

If you are the authorized requestor, please sign and date the authorization. Information will not be released without proper signatures.

SUPPORTING DOCUMENTATION REQUIRED FOR LEGAL REPRESENTATIVES:

If you are a legal representative for the patient, please provide copies of legal documents that prove your authority to sign the authorization on behalf of the patient.

Send your Request and Authorization to Copy Health Information to the UC Organization that maintains your records.