AT THE FOREFRONT
UChicago Medicine
Ingalls Memorial

UChicago Medicine Ingalls Memorial Hospital
Request and Authorization for Medical Records

Section I: PATIENT INFORMATION

Patient Name (last, first, middle initial):			
Birthdate:		**Medical Record Number:**	
Address:			
City:	**State:**	**Zip:**	**Phone:**

Method of Delivery: ____ Mail ____Secure Portal - provide email_____

____ Other (e.g. electronic): _____

I authorize release of records from the following facilities:

☐ University of Chicago Medical Center ☐ Other _____

☐ Ingalls Memorial Hospital ☐ All UChicago Medicine Health System Locations

Section II: INFORMATION REQUESTED and PURPOSE:

I authorize the UCM Organization to use or disclose the following health information during the term of this Authorization: (*check all that apply)*

- ❑ Clinic visit
- ❑ Emergency Room Report
- ❑ Surgical (operative report, path report)
- ❑ Hospital Records (Abstract)
- ❑ General Hospital Records (includes documents such as flowsheets, patient education, etc.)
- ❑ Radiology Images (Please contact Radiology at 708-915-5602)
- ❑ Test results (Specify: Lab, radiology reports, EKG, etc.)
- ❑ Pathology Slides (Please contact Pathology at 773-915-5602)
- ❑ Other: _____
- ❑ Billing records (Contact billing office @ 708-333-1100)
- ❑ Therapy Notes (Specify: PT, Speech, Radiation, Chemo)
- ❑ Photographs (please specify) _____
- ❑ Mental Health Clinic Visit
  - -OR-
  - ❑ Psychological Testing Final Report
  - ❑ Medication Ordered/Given
  - ❑ Other: _____

Dates of Treatment/Service:_____

For example: specific date 1/25/18; or range of dates Jan-July 2010; or all dates of service. If dates are not provided, UCM will only release the last 5 years of your medical record.

Are the Records Needed For An Appointment: ❑YES ❑ NO Appointment Date: _____

The Purpose/Need of the Disclosure: _____

For example: workers' compensation, school requires immunization records; request of patient.

I understand that UChicago Medicine will/will not (circle one) directly or indirectly receive any items of value from any third party in connection with the use of the health information.

Section III: RECIPIENT:

If this information is not being delivered to me, then deliver my health information to:

Name of Person:	**Phone Number:**
Name of Organization:	**Fax Number**:
Street Address:	
City, State, Zip:	

By checking any of the boxes below, I am specifically authorizing the UC Organization(s) to use and/or disclose the category of confidential information indicated next to the box, if applicable to this authorization.

- ❑ Information about a Mental Illness or Developmental Disability**
- ❑ Psychotherapy Notes (which are not part of the official medical record)
- ❑ Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ❑ Information about Communicable Diseases
- ❑ Information about Sexually Transmitted Disease(s)
- ❑ Information about Substance (i.e., alcohol or drug) Abuse
- ❑ Information about Abuse of an Adult with a Disability
- ❑ Information about Sexual Assault
- ❑ Information about Child Abuse and Neglect
- ❑ Information about Genetic Testing
- ❑ Information about Infertility/IVF/Artificial Insemination

Section V: NOTICE TO PATIENT

I understand that this consent is valid for 90 days from the date of signature, or until calendar date _____/_____/_____.

(This authorization request applies only to records with dates of service up to the date of signature, even if the valid date extends beyond the date of signature.)

Note: The term for mental health records must be stated—you may not use "no expiration." If no termination event is filled in, then this Authorization will expire 90 days after the date signed below.

I understand that I may change my mind and revoke this Authorization in writing at any time by notifying the Health Information Management Office. I understand that changing my mind will not affect my treatment. The revocation will not apply to the extent that any UC Organization has already taken action where it relied on my permission. *Send revocations to: Health Information Management Department, University of Chicago, MC0978, 5841 S. Maryland Ave., Chicago, IL 60637*. I understand that I have the right to inspect or copy any information used/disclosed under this authorization. I understand that once my health information is disclosed to the recipient, no UC Organization can guarantee that the recipient will not re-disclose the health information to a third party or as required by law. The third party may not be required to comply with this Authorization or privacy laws. Illinois law does not allow the re-disclosure of AIDS/HIV, genetic testing, mental health and developmental disabilities information by the receivers of the information except in defined situations allowed by law. Federal Confidentiality Rules, 42 CFR part 2, prohibits unauthorized disclosure of substance use records.

I understand that I may refuse to sign this Authorization, and if I do refuse, my ability to obtain treatment will not be affected unless (a) the only purpose of treatment is to create health information for the disclosure listed above, or (b) my treatment is related to my participation in a research study.

I have read and understand this Authorization and had a chance to ask questions about the disclosure of the health information. I authorize each UC Organization to use/disclose my health information in the manner described above.

_____ _____

*Signature of Patient or Personal Representative** *Date*

_____ _____

Name of Personal Representative (If applicable)* *Relationship to Patient*

**The Personal Representative is the patient's decision maker. It can be the parent if the patient is a minor, legal guardian, health care surrogate, or other person.*

*****A witness signature is required for the release of information about a mental illness or developmental disability.***

_____ _____

Signature of Witness *Date*

_____

Printed Name of Witness

Submit the completed authorization by mail, fax or email.

Mail to:
UChicago Medicine Ingalls Memorial
Attn: Medical Records
One Ingalls Drive
Harvey, IL 60426

If you have questions: (708) 915-6201

Email to: ROI@ingalls.org

For all UChicago initiated requests, provide a copy of the completed form to the patient.