



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

For the purposes of release of health information, records are available at the following University Of Chicago Organizations: The University of Chicago Hospitals, The UCCH Pediatric Specialty Clinics, The UCHHS Regional Doctors Offices, and The University of Chicago Physicians Group.

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 Hospitals, 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 – Center For Advanced Medicine
- Outpatient Registration 2nd Floor – Center For Advanced Medicine

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 releasing 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 charges:

Number of Copies	Medical Records	Microfilm
Pages 1 - 25	\$0.84 per page	\$1.39 per page
Pages 26 – 50	\$0.56 per page	\$1.39 per page
Pages 51 and up	\$0.28 per page	\$1.39 per page
X-ray Film	\$ 5.00 per Film	
X-rays on CD (multiple exams)	\$ 20.00 per CD	

- When patients request copies for parties other than themselves and health care providers, the recipient of those copies will be charged a processing fee of \$20, the per page/film fee listed above and postage.

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 responsible for maintaining your records (see reverse side for contact information)

02/16/06



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

UNIVERSITY OF CHICAGO HOSPITALS AND CENTER FOR ADVANCED MEDICINE

Medical Records
University of Chicago Hospitals
Medical Records Department
MC0978
5841 S. Maryland Avenue
Chicago, IL 60637
Phone: 773-702-1637

Billing Records
University of Chicago Hospitals
Patient Accounts Department
MC1068
8201 Cass Avenue
Chicago, IL 60561
Phone: 773-702-6664
Fax: 773-702-8608

Radiology Films
University of Chicago Hospitals
Radiology Department-MC2026
Radiology Film Requests
5841 S. Maryland Avenue
Chicago, IL 60637
Phone: 773-702-9662

UNIVERSITY OF CHICAGO CHILDREN'S HOSPITAL SPECIALTY CLINICS

Medical Records
UCCH Pediatric Specialists
8528 Broadway
Merrillville, IN 46410
Phone: 219-756-1200

Medical Records
UCCH Pediatric Specialists
7350 W. College Drive
Palos Heights, IL 60463
Phone: 708-448-8000

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

UCHHS REGIONAL DOCTORS OFFICES

Child Life Center
19550 Governors Highway, Suite 2500
Flossmoor, IL 60422
Phone: 708-799-7600

U. of C. Physicians Group
4801 Southwick Drive, 5th Fl
Matteson, IL 60443
Phone: 708-748-2310

U. of C. Physicians Group
1111 East 87th Street
Chicago, IL 60619
Phone: 773-702-2900

U of C Physicians Group
1301-A E. 47th Street
Chicago, IL 60653
Phone: 773-702-2600

Regional Doctors Office Billing Records
P.O. Box 2139
Bedford Park, IL 60499-2139
Phone: 866-209-0027
Fax: 773-834-3978

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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02/1/07

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
- Social Security Number (if available)
- 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, venereal 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.

02/16/06