University of Chicago Medicine Health System
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 REQUESTS@RECDEP.COM
____MyChart* ____ Other (e.g. electronic): _____

* If you are requesting records for yourself, you can receive your records through MyChart. If need access to MyChart, visit The University of Chicago Medicine's website at https://www.uchicagomedicine.org and click on Patients & Visitors.

I authorize release of records from the following facilities:

☐ University of Chicago Medical Center ☐ All UChicago Medicine Health System Locations
☐ Ingalls Memorial Hospital ☐ Other _____

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.)
- ❑ Therapy Notes (Specify: PT, Speech, Radiation, Chemo)
- ❑ Test results (Specify: Lab, radiology reports, EKG, etc.)
- ❑ Other: _____

- ❑ Billing Records (UCM: 773-702-6664, ING: 708-333-1100)
- ❑ Radiology Images (UCM: 773-702-1788, ING: 708-915-5602)
- ❑ Pathology Slides (UCM F: 773-834-2595 , ING F: 708-915-3786)
- ❑ Echocardiogram Images (UCM F: 773-702-1034, ING F: 708-915-3119)
- ❑ 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:** (248) 357-3330
Name of Organization:	RECORDS DEPOSITION SERVICE	**Fax Number:** (248) 357-3337
Street Address:	29100 NORTHWESTERN HWY., STE. 300	
City, State, Zip:	SOUTHFIELD, MI 48034	

PLEASE READ THIS PAGE CAREFULLY

Section IV: SPECIFIC CONSENT

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 _____/____/_____.

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:
University of Chicago Medical Center
Attn: Medical Records Dept MC0978
5841 S Maryland Ave
Chicago, IL 60637

Fax to: (708) 915-5675
For Questions, call (773)702-1637

Email to: himauthforrecords@uchospitals.edu

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